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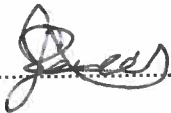
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**Rest and Restitution:
Convalescence and the Public Mental Hospital in
England, 1919–39**

by

Stephen Soanes

**A thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy in History**

**University of Warwick,
Department of History,
Centre for the History of Medicine
January 2011**

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Declaration

I hereby declare that this thesis has not been submitted, either in the same or different form, to this or any other University for a degree.

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Abstract

Previous histories have tended to look beyond the asylum for innovations in early twentieth-century mental healthcare. In contrast, this thesis appraises the mental hospital as the nexus for a new approach to convalescent care and makes the case for a more integrated conception of institutional and community care in the interwar period. Despite a concentration of convalescent facilities in certain areas, this study argues that the period between 1919 and 1939 witnessed the emergence of a more standardised and coordinated model of care that traversed institutional boundaries. Consequently, it challenges a prevailing view that sees asylum care as separate from developments in borderline care in this period. It is demonstrated that public mental hospitals after 1919 widely added new convalescent villas within their grounds, whilst voluntary organisations diversified and extended their community-based cottage homes. This thesis explores the reasons for this expansion and seeks to explain the functions it served those who planned, managed and utilised mental convalescent homes.

It is argued that those with professional interests in the mental hospital focused on the 'modern' convalescent villa partly as a strategic response to the low status of mental hospitals in the 1920s, as well as to alleviate overcrowding, and oversee recovery in managed and healthful environments. The spatial and rhetorical connection between the admission hospital and the convalescent villa allowed these interests to claim they formed part of a broader movement of mental hygiene and early treatment. In contrast, patient representations of cottage homes offer an alternative perspective of convalescence as a holiday and break from social demands.

Particular attention is paid to the case of the London County Council. The analysis focuses on descriptions of convalescent homes found in organisational records. These are compared with plans and photographs to make sense of the uses such homes served.

Abbreviations

BBMHS	Bath and Bristol Mental Health Society
BoC	Board of Control
BRO	Bristol Record Office
CAMW	Central Association for Mental Welfare
DRO	Devon Record Office
ESRO	East Sussex Record Office
LCC	London County Council
<i>JMS</i>	<i>Journal of Mental Science</i>
LAB	Lancashire Asylums Board (later Lancashire Mental Hospitals Board)
LMA	London Metropolitan Archives
MACA	Mental After-Care Association
MoH	Ministry of Health
MoP	Ministry of Pensions
MRC	Modern Records Centre
NCMH	National Council for Mental Hygiene
NRO	Norfolk Record Office
QAF	Queen Adelaide Fund
(R)MPA	(Royal) Medico-Psychological Association
TNA	The National Archives
WLHUM	Wellcome Library for the History and Understanding of Medicine

Introduction

The problems 'convalescence' historically addressed remain highly pertinent to current practice in mental health care, even though the term itself has a relatively peripheral place in contemporary psychiatry. Issues of stigmatisation, social isolation and behavioural nonconformity amongst the recovering mentally ill have historically raised questions over their place between the twin poles of institution and society. These issues were at the heart of mental convalescence, as a practice that in the early twentieth century provided a 'half-way home' for patients, strategically and variably situated between mental hospital and home. Unlike convalescence in many cases of somatic disorder, therefore, mental convalescence extended beyond the consolidation of biological recovery and addressed fundamental issues about recovering patients' identity and belonging. Ongoing debates over the respective role of community care and institutionalisation in mental health indicate that those interested in psychiatry continue to disagree over the best place for mental treatment.¹ This thesis explores comparable debates and assumptions over the appropriate place for the mental convalescent in interwar England. Recent explorations into the origins of the modern recovery movement have usefully raised the 'transformative implications' of revised conceptions of recovery to mental health practice.²

The specific meanings and methods attached to mental convalescence

¹ See for example Andrew Scull, 'Mental Patients and the Community: A Critical Note', *International Journal of Law and Psychiatry* **9** (1986), pp. 189-91; J.K. Wing, 'The Functions of the Asylum', *British Journal of Psychiatry* **157** (December 1990), pp. 822-5; Graham Thornicroft and Michele Tansella, 'Components of a Modern Mental Health Service: A Pragmatic Balance of Community and Hospital Care', *British Journal of Psychiatry* **185** (October 2004), pp. 283, 288.

² Larry Davidson, Jaak Rakfeldt and John Strauss, *The Roots of the Recovery Movement in Psychiatry: Lessons Learned* (Oxford and Hoboken, NJ: Wiley-Blackwell, 2010),

between 1919 and 1939 were therefore potentially quite different from modern notions of psychiatric recovery, even though both relate to improvement. While Peter Watkins has suggested 'recovery is a new watchword' in psychiatry, between 1919 and 1939 psychiatrists, voluntary workers and patients widely comprehended mental recovery in terms of convalescence.³ What this term meant to early twentieth century providers and recipients connected to the public mental hospital system, and the implications of its practice, form the central concern of this thesis.

Between the wars, the concept of convalescence extended far beyond the limited if growing provision made for its practice. Efforts directed to the care of this minority of patients reflected wider concern for the problems both institutions and wider society might present recovery. Certainly, in absolute terms, the numbers provided with convalescence through the MACA remained small: only 3.7 per cent of the 9,369 patients discharged from public mental hospitals in 1924 received aftercare in its cottage homes.⁴ This is broadly consistent with official figures, which suggest that around 5–10 per cent of patients in the 1910s and 1920s received some form of aftercare, either in the form of convalescence, monetary grants or other forms of

³ Peter Watkins, *Mental Health Practice: A Guide to Compassionate Care* (London: Elsevier, 2009, second edition), p. 67. In contrast, the term 'convalescence', for instance, has appeared only four times in the *British Journal of Psychiatry* [*BJP*] in the decade between 2001-10. This compares starkly with comparable citations for 'convalescence' in the *BJP*'s predecessor journal, the *Journal of Mental Science*, which appeared in 136 articles in the 1920s, and a further 140 in the 1940s.

⁴ The numbers provided with convalescence in the MACA's homes was smaller, yet still substantial. Registers indicate 351 patients received convalescence in 1924, compared with a total of 9,368 patients discharged the same year. Wellcome Library for the History and Understanding of Medicine [WLHUM], Mental After-Care Association [MACA], SA/MAC/G.2/3-5, Agenda Case Books, 1918-1924.

assistance.⁵ Despite these relatively small numbers of recipients, it is notable that provision for such services continued to develop and grew substantially in the years to 1939, whilst a host of central and local government, voluntary agencies and advocates pressed and worked for its further extension. It is the support diverse groups gave to the promotion of mental convalescence in this period that this thesis seeks to explain. Such interest in mental convalescence has been largely absent from the historiography of early twentieth-century public asylum treatment, yet it offers to illuminate the factors that have historically shaped care-giving for the improving patient.

1. Definitions

The title of this thesis reflects the duality of convalescence both as a rest from institutional treatment and as the first step towards restitution to the wider community. At once, the concept of convalescence looked forward to health as an optimistic precursor to recovery and backwards to former sickness through supervisory and recuperative practices intended to safeguard against relapse. Derived from the Latin *con valescere*, meaning ‘to grow strong/ well’, the term convalescence etymologically denotes a dynamic

⁵ The BoC recorded in 1924 that ‘only 939 (9.6 per cent)’ of patients had received aftercare, whilst more than half of all mental hospitals had made no applications. In 1913, Hubert Bond had recorded that the 380 applications handled in the previous year meant that ‘not more than one in eighteen discharged on recovery is brought under the [Mental After-Care] Association’s cognizance’. Hubert Bond, ‘After-Care in Cases of Mental Disorder, and the Desirability of its More Extended Scope’, *Journal of Mental Science* **60** (April 1913), p. 278; Board of Control [BoC], *Annual Report for 1924* (London: H.M. Stationary Office, 1924), p. 27.

phase of improvement.⁶ It is this sense of relative passivity that has perhaps distinguished it from related terms such as rehabilitation, which have historically presupposed a more active participation of patient or medical practitioner in the recuperative process. Whereas convalescence has historically carried connotations of rest and the natural restoration of former health, an editorial in the *British Medical Journal* in 1927 defined rehabilitation as a more skilled process of ‘making good... the organism’. Such perceptions of rehabilitation as a meditated and managed intervention are also apparent in a more recent *Oxford English Dictionary* entry for rehabilitation. This has interpreted rehabilitation as ‘restor[ation]... to health or normal life by training or therapy’, and consequently through direct intervention during the phases of improvement. Due to these differences, this thesis focuses particularly on convalescence and the specific practices and ideas that it comprised.

Early twentieth-century medical definitions generally presented convalescence as a stage after acute illness or disease in which specific treatments had little effect. However, most also identified residual infirmities, such as Bethlem’s medical superintendent Thomas Beaton, who in 1922 adverted to the ‘apathy, lack of initiative, and... submissiveness’ convalescents typically displayed.⁷ Superintendents therefore identified

⁶ Richard Quain, *A Dictionary of Medicine* (London: Longmans, Green and Co, 1890), p. 295; Henry W. Cattell, *Lippincott’s New Medical Dictionary: A Vocabulary of the Medical Terms used in Medicine and the Allied Sciences* (London and Philadelphia: J.B. Lippincott, 1910), p. 226; Henry A. Skinner, *The Origin of Medical Terms* (London: Balliere, Tindall and Cox, 1949), p. 104; Daphne Fallows, *Convalescence: A Neglected Need?* (London: Cicely Northcote Trust, 1989), p. 1; Jenny Cronin, ‘The Origins and Development of Scottish Convalescent Homes, 1860-1939’ (unpublished PhD thesis, University of Glasgow, 2003), p. 159.

⁷ [Thomas Beaton, cited in] Bedford Pierce, ‘Recovery from Mental Disorder’, *Proceedings of the Royal Society of Medicine* (11 April 1922), p. 64.

convalescents on the basis of functional incapacities and residual pathological traits. By questioning the mental robustness and self-reliance of convalescents, superintendents such as Beaton justified continued supervision of these patients as a safeguard against further instability.⁸ In contrast, as Chapter Four suggests, patients often represented their convalescence as a break from social pressures, rather than a medical intervention. Their responses suggest many viewed it as a preparatory hiatus prior to reengagement with community life and consequently interpreted convalescence according to social rather than medical frames of reference.

As such, the meaning of the various terms used to describe recovery was subjected to continual inter-subjective reinterpretation. In different contexts, convalescence reflected legal, medical and social values. Printed sources indicate that the term had a wide cultural resonance in interwar society and was applied to the body politic as well as to the corporeal body and mind. Political commentators regularly anthropomorphised improvements within nation states in the aftermath of World War One. Thus, Alfred Zimmern's *Europe in Convalescence* (1922) envisaged an entire continent recuperating from the 'psychological consequences of war strain'.⁹ Analysis of international affairs coverage in *The Times* in this period reveals that journalists and politicians frequently spoke of countries as geo-politically 'convalescent' entities.¹⁰ Winston Churchill typified this tendency and in at

⁸ Other medical superintendents also represented convalescence as an 'unstable' condition. See Hubert Bond, 'After-Care in Cases of Mental Disorder, and the Desirability of its More Extended Scope', *Journal of Mental Science* **60** (April 1913), pp. 280-1; Henry Rayner, 'Mental After-Care', *Journal of Mental Science* **70** (July 1924), p. 358.

⁹ Alfred E. Zimmern, *Europe in Convalescence* (London: Mills and Boon, 1922), p. 3.

¹⁰ E.g., 'Workers and Education, Hastening Post-War Convalescence, Lord Inchcape's Views to the Editor', *The Times* (Wednesday 29 March 1922), **42992**, p. 8, col. B; 'The Right Idea, American Tribute to Britain', *The Times* (Thursday 15 March 1923), **43290**, p. 11, col.

least three speeches referred to Britain as a country in 'convalescence' after the War.¹¹ These usages indicate the elasticity of the concept in this period, and its widespread application to describe the recovery of nations and economies, as much as the recovery of individual somatic or mental health. The wide range of meanings attached to convalescence between 1919 and 1939, supports Ian Hacking's approach to such classifications as contingent and transient, historically- and socially-embedded ideas.¹² Such non-specificity in the use of this term suggests the word itself held a diffuse and general meaning, contested and applied to cultural and social contexts beyond illness.¹³

In the context of the mental hospital, it is also possible that the recipients of convalescence changed over time and that different diagnoses became the focus for convalescent care. To ascertain how far this occurred would require research beyond the scope of this thesis, perhaps through systematic record linkage between the MACA's case-books (which do not record the patient's original diagnosis) and mental hospital case records. The case-files consulted for this thesis are insufficient for the purpose as only a few have survived, whilst voluntary, official and local authority records are surprisingly

E; 'The Convalescence of Austria', *The Times* (Saturday 23 May 1925), **43969**, p. 15, col. B; Sir William Goode, 'The Revival of Hungary, A Year's Progress', *The Times* (Saturday 23 May 1925), **43969**, p. 15, col. A.

¹¹ 'Mr Churchill at Birmingham, The French Debt, M. Caillaux's Letter', *The Times* (Thursday 17 September 1925), **44069**, p. 14, col. B; 'Economic Strength of Britain, Mr Churchill's Tribute', *The Times* (Saturday 27 November 1926), **44440**, p. 14, col. C; 'Financial Record of the Government, Mr Churchill's Reply to Critics', *The Times* (Friday 11 November 1927), **44736**, p. 9, col. D.

¹² Ian Hacking, *The Social Construction of What?* (London; and Cambridge, Mass: Harvard University Press, 1999).

¹³ The only author to publish a book-length study on convalescence in Britain this period, Elizabeth Greene Gardiner, also recognised that there was 'no widely accepted definition of a convalescent home either among the British or the Americans'. Elizabeth Greene Gardiner, *Convalescent Care In Great Britain* (Chicago: University of Chicago Press, 1935), p. 8.

silent on the types of case felt most suitable for convalescence. In a typical appeal to the broad application of the MACA's work, its chairman would claim in 1934 that the aftercare it provided benefited cases of 'neurosis and psychosis, whether incipient or the more severe types of mental disease'.¹⁴ Rhetorically at least, the MACA therefore claimed to help a wide range of patients, though further quantitative research into referral patterns is needed to determine the distribution of convalescence across different diagnoses. Equally, a study of mental hospital case-notes may reveal more about selection procedures for convalescence within mental hospitals. Psychiatric textbooks at least hint at some differentiation between the uses of convalescence in different diagnoses. It does appear that superintendents distinguished between convalescence in different cases, and concentrated for example on the specific strategies needed to ward against suicide amongst convalescent melancholics.¹⁵ In cases where recovery occurred quickly with marked improvement the concept of 'convalescence' perhaps applied less readily; particularly interesting in this respect would be to investigate the impact of physical therapies such as insulin comas and ECT on approaches to recovery.

The chapters that follow approach convalescence as a contingent category, the definition and conceptual vitality of which depended upon shared cultural understandings of its value. Consequently, I approach convalescence as an 'interactive kind', that is to say a classification formed

¹⁴ WLHUM, MACA, Press Cuttings from Albums, SA/MAC/H.1/2-5, Reginald Worth, 'After-Care of Mental Patients', paper given at CAMW Public Health Conference, 1934.

¹⁵ T.S. Clouston, *Unsoundness of Mind* (London: Methuen, 1911), pp. 151-3, 283; Hubert J. Norman, *Mental Disorders: A Handbook for Students and Practitioners* (Edinburgh: E. & S. Livingstone, 1928), p. 45; Henry Yellowlees, *Clinical Lectures on Psychological Medicine* (London: J. & A. Churchill, 1932), pp. 32, 70-2.

out of the collective interpretations of those that described, discussed, and disagreed over its purpose.¹⁶ Even at a given moment, interpreters applied different criteria when making sense of what it meant to be 'convalescent'. Most notably, the professional association of British and colonial psychiatrists, the Medico-Psychological Association (RMPA), contended that the Macmillan Commission in its investigations into British mental hospitals between 1924 and 1926, had 'missed the main point' of convalescence. Here the RMPA felt the Macmillan Commission had overly emphasised its legalistic dimensions, as a measure designed to ensure prompt release from detention, when the Association argued 'its real purpose' was to test the extent of nervous and mental recovery.¹⁷ To some extent, interwar commentators recognised ambiguities over what convalescence meant, even as they individually contributed to its definition. H.P. Macmillan himself was recorded in the Commission's minutes as having regarded convalescent patients a 'very puzzling case', caught in a 'twilight stage' between sickness and health.¹⁸ The Mental After-Care Association (MACA) repeatedly imagined convalescence as a transitional 'bridge' and 'half-way house', using metaphors that positioned patients indeterminately between medicine and society. US-based researcher and social worker Elizabeth Greene Gardiner in *Convalescent Care in Great Britain* (1935) attributed inconsistencies and gaps in service provision for convalescence to precisely such ambiguities over where the practice lay between the 'overlapping circles' of medical and

¹⁶ This includes those named or treated as convalescents themselves, as a class of patient that reacted to their labelling, and made sense of their condition and prognosis according to their understandings of what it meant to be 'convalescent'. Hacking, *The Social Construction of What?*, pp. 103-4, 116.

¹⁷ 'The Report of the Royal Commission on Lunacy and Mental Disorder', *Journal of Mental Science* **72** (October 1926), p. 604.

¹⁸ *Minutes of Evidence Taken before the Royal Commission on Lunacy and Mental Disorder* (London: H.M. Stationary Office, 1927), p. 553, 25 February 1925, Q. 12,870.

social responsibility.¹⁹ Gardiner's argument in particular suggests the potential for independent patient and carer interpretations of convalescence, beyond the contested inter-professional debates over its meaning of the RMPA and Macmillan Commission.

Even so, mental convalescence took place within dedicated home-like spaces, which provided a relatively dedicated space for its performance. To a considerable extent, the MACA's post-1880s cottage homes, and mental hospital villas developed from the 1900s, identified convalescence as a discreet field, distinct from other recuperative and therapeutic practices. These had little if any organisational connection with homes for those recovering from somatic disorders in this period. General convalescent homes before 1939 widely debarred entry to patients recovering from psychiatric disorders.²⁰ In turn, local authority and voluntary homes for mental convalescents excluded those with primarily somatic disorders like tuberculosis and other conditions such as epilepsy. The MACA further required its matrons to take only those patients it had referred to them. By the early twentieth century, these homes occupied a place amongst a range of specialised short-term residential institutions, which aimed to consolidate the health of the physically and mentally ill. These shared comparable therapeutic rationales, based on the removal of individuals to more healthful environments than those available in hospitals or patients' own homes.²¹

¹⁹ Gardiner, *Convalescent Care*, p. 8.

²⁰ *Ibid.*, p. 61; Cronin, 'Scottish Convalescent Homes', p. 165.

²¹ Sanatoria had developed in England from the 1840s, and more especially from the 1860s, and were not at first restricted to TB cases, but rather for all those with somatically-attributed disorders who needed a place of healing. J.R. Bignall has suggested that the terms 'sanatorium' and 'convalescent home' continued to be used interchangeably at the turn of the century. Nevertheless, dedicated sanatoria for TB patients became more widespread after 1900. So too, Harriet Richardson has charted a similar specialisation in the provision of

Each type of home targeted specific types of patient, however, and as Chapters Two and Three explore, helped define the specific features of 'mental convalescence', even as providers, managers and users contested their function.

This thesis therefore considers convalescence as a category largely defined through buildings created or selected for its management. Consequently, it approaches this imprecisely-defined category, via homes and villas that gave it spatial and procedural form as a specialised sphere of activity.²² Patients outside these institutions may also have considered themselves 'convalescents', as sentient and self-reflexive individuals who as Ian Hacking has argued, would have electively applied and adapted those classifications that best fitted their personal concepts of recovery.²³ However, it is difficult to locate these self-descriptions, or to regard them as stable categorisations, when, as Allan Beveridge has noted, patients may have continually reinterpreted and re-classified themselves.²⁴ While classifiers similarly displayed some uncertainty over the conceptual parameters of convalescence, the buildings they allocated for its management at least indicate something of how they envisaged its function. As William Whyte has argued, these functions have been subject to continual reappraisal, evident in the previous history of many cottage homes and villas for other residential

villa colonies for epileptics in England between c.1884-1904. See J.R. Bignall, *Frimley: The Biography of a Sanatorium* (London: Seven Corners, 1979), pp. 6-8, 15-18; Harriet Richardson, *English Hospitals, 1660-1948: A Survey of their Architecture and Design* (Swindon: Royal Commission on the Historical Monuments of England, 1998), pp. 177-8.

²² Bill Hillier and Juliette Hanson, *The Social Logic of Space* (Cambridge: Cambridge University Press, 1984), pp. 184-5; Lindsay Prior, 'The Architecture of the Hospital: A Study of Spatial Organisation and Medical Knowledge', *British Journal of Sociology* **39**:1 (1988), pp. 89-90.

²³ Hacking, *The Social Construction of What?*, pp. 31-4.

²⁴ Allan Beveridge, 'Life in the Asylum: Patients' Letters from Morningside, 1873-1908', *History of Psychiatry* **9** (1998), pp. 449, 462.

and institutional purposes.²⁵ Building plans therefore represented spaces with multiple potentially diametrically-opposed uses, rather than a readily-deducible abstraction of a stable function.²⁶ Consequently, this thesis approaches convalescence as a contested classification made visible through relatively stable spaces, which were nevertheless subject to reinterpretation over time.

2. Convalescence in Historical and Historiographical Context

While some involved in the organisation of modern medical services have questioned where convalescence has gone, historians have given little consideration to the origins and development in relation to mental hospitals.²⁷ Certainly, historians of psychiatry have indicated that convalescence had a traditional place within asylums that stretched back almost as long as these institutions. From the late eighteenth and early nineteenth centuries, several asylums established wards for convalescents.²⁸ Outside the asylum, Jonathan Andrews (*et al.*) has suggested mental aftercare had even earlier

²⁵ William Whyte, 'How do Buildings Mean?: Some Issues of Interpretation in the History of Architecture', *History and Theory* **45** (May 2006), 153-77.

²⁶ Hillier and Hanson have suggested plans and buildings display an internal 'logic', in contrast to Lindsay Prior and Iain Bordain, who have suggested historians must interpret them within the discourse that led to their production and subsequent alteration. Whyte has gone further, in suggesting that historians should look beyond the point of conception, to the continual transposition and translation of these spaces by different interpreters over time, even where no material changes take place to their structure. See Hillier and Hanson, *The Social Logic of Space*; Prior, 'The Architecture of the Hospital'; Iain Bordain, 'The Politics of the Plan', in Iain Bordain and David Dunster (eds), *Architecture and the Sites of History: Interpretations of Buildings and Cities* (Oxford: Butterworth, 1995), pp. 214-26; Whyte, 'How do Buildings Mean?'.

²⁷ Fallows, *Convalescence*; Stefan Cembrowicz, 'On Convalescence', *Lancet* **344**: 8927, p. 966.

²⁸ Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), pp. 67-8; Leonard Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England* (London and New York: Leicester University Press, 1999), pp. 193-4; Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum, St Andrew's Hospital, 1810-1998* (Woodbridge, Suffolk; and New York: Boydell, 2003), p. 34.

antecedents, traceable to at least Edward Tyson's bequest, enacted in 1708, for monetary payments to Bethlem's discharged patients.²⁹ Less clear, however, is what position convalescents occupied between asylums and the community beyond. Despite the longevity of its association with asylum treatment, convalescence occupies a marginal place in the history of psychiatry, much as Jenny Cronin has found in general medicine.³⁰ This thesis therefore considers the relationship of one classification – convalescence – to broader institutional treatment on one hand and social forms of aftercare on the other. As such, it responds to histories of psychiatry that have sought to identify the extension of mental classifications and therapeutic stratagems beyond the asylum.³¹

The simultaneous construction of convalescent villas within mental hospitals and expansion of voluntary cottage homes in the community neatly reflected the ambiguous position of convalescence, within Elizabeth Gardiner's 'overlapping circles' of medicine and society. Such blocks and homes received widespread support from those who investigated, regulated and implemented mental hospital services between the wars. The two major official interwar committees on mental disorder called for both convalescent

²⁹ Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker, and Keir Waddington, *The History of Bethlem Hospital* (London and New York: Routledge, 1997), pp. 271, 276.

³⁰ Cronin, 'Scottish Convalescent Homes', pp. 3-8.

³¹ Peregrine Horden and Richard Smith (eds), *The Locus of Care: Families, Institutions and the Provision of Welfare since Antiquity* (London and New York: Routledge, 1998); Peter Bartlett and David Wright, *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London; and New Brunswick, NJ: Athlone, 1999); Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient and the Family in England, 1820-1860* (London and Los Angeles, CA: University of California Press, 2006); Catharine Coleborne, 'Challenging Institutional Hegemony: Family Visitors to Hospitals for the Insane in Australia and New Zealand, 1880s-1910s', in Graham Mooney and Jonathan Reinartz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (Amsterdam and New York: Rodopi, 2009), p. 289; Catharine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914* (Basingstoke, Hants and New York: Palgrave Macmillan, 2010).

villas within mental hospitals and an extension of community-based convalescence through the voluntary sector.³² So too, in the RMPA's view, recovery was best managed through an initial stage of institutional convalescence under direct medical supervision, followed by a subsequent period at home.³³ Likewise, the government department responsible for mental hospitals in England and Wales, the Board of Control (BoC), repeatedly pressed mental hospitals to develop their own onsite villas, and at the same time make more use of the MACA's homes.³⁴ The similarities between these organisations' recommendations hints at some measure of consensus, firstly over the importance of convalescence, and secondly over the extent to which it should coexist concurrently across both medical and social spheres. This placed an onus of responsibility on mental hospitals, as well as voluntary agencies. Pressure for change also came from those such as the investigative journalist Paul Winterton, who in the late 1930s called for mental hospitals to regard aftercare as a necessity and appealed for a concurrent expansion in voluntary effort. Winterton regarded convalescent homes as an integral part of an effective mental hospital system, and attacked those that failed to provide aftercare as therapeutically and socially retrogressive.³⁵

Despite the public emphasis these different agencies placed on aftercare and convalescence, the significance of these practices has received negligible historical attention. Several historians have raised the

³² See Chapter One of this thesis.

³³ 'The Reports of the Royal Commission on Lunacy and Mental Disorder', *Journal of Mental Science* **72** (October 1926), p. 605.

³⁴ See Chapters Two and Three of this thesis.

³⁵ Paul Winterton, *Mending Minds: The Truth about Our Mental Hospitals* (London: Peter Davies, 1938), pp. 162-3.

organisational relationship between charities and local authorities in mental aftercare. Few, however, have considered what motivated these arrangements, or their effect on how patients experienced recovery.³⁶ The most significant study on convalescence, by Jennifer Cronin, has specifically excluded institutions for the mentally ill.³⁷ Cronin's thesis, which deals with the purpose and extent of general convalescent homes in Scotland, has nevertheless identified themes that resonate with the very different contexts of institutional psychiatry. In particular, Cronin has argued that as recuperative services grew in scale over the early twentieth century, the concept of convalescence became more diffuse, due to its progressive reinterpretation as both a preventive measure and a form of holiday.³⁸ This would appear to correspond with a broader erosion in the boundaries between medicine and society in this period, which saw health centres, out-patient clinics, and domiciliary interventions introduced for a variety of borderline somatic and psychiatric ailments.³⁹ What role convalescence fulfilled in mental health services, as the distinction between sickness and health became ever more blurred is, however, broadly unaddressed in the history of psychiatry. Certainly, there are clues in this literature that mental

³⁶ Madeline Roof, *Voluntary Societies and Social Policy* (London: Routledge & Kegan Paul, 1957), pp. 116-9; Kathleen Jones, *Mental Health and Social Policy, 1845-1959* (London: Routledge & Kegan Paul, 1960), pp. 103-6; Kathleen Jones, *A History of the Mental Health Services* (London: Routledge & Kegan Paul, 1972), pp. 266-7; Fisher, 'Getting Out of the Asylum', pp. 241, 209-10, 243, 254; Vicky Long, 'Changing Public Representations of Mental Illness in Britain, 1870-1970' (unpublished PhD thesis, University of Warwick, 2004), pp. 181-231.

³⁷ Cronin, 'Scottish Convalescent Homes', p. 9; Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health* (London and New York: Routledge, 2006), pp. 80-97.

³⁸ Cronin, 'Scottish Convalescent Homes', pp. 3, 52, 154, 275-6, 280-1.

³⁹ Abigail Beach, 'Potential for Participation: Health Centres and the Idea of Citizenship, c.1920-1940', in Christopher Lawrence and Anna K. Mayer (eds), *Regenerating England: Science, Medicine and Culture in Inter-war Britain* (Amsterdam; and Atlanta, GA: Rodopi, 2000), pp. 203-30; Louise Westwood, 'Avoiding the Asylum: Pioneering Work in Mental Health Care, 1890-1939' (unpublished PhD thesis, University of Sussex, 1999); Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London: HarperCollins, 1997), p. 645.

convalescence may have undergone a comparable reconceptualisation to that Cronin has identified. Most notably, Kathleen Jones has already indicated that the MACA had begun to provide early care convalescence for mental patients by 1924.⁴⁰ This suggests that at an organisational level, convalescence expanded as a practice to encompass a greater variety of patients than in a previous era; something explored in more detail in Chapter Three. The theories and purposes behind such initiatives, however, have hitherto remained largely unexplored.

The rhetoric of the RMPA, BoC, and MACA suggests that those involved with the administration, regulation and provision of psychiatric services after 1919 wished to promote a proliferation in convalescent services for mental patients. How far mental hospitals and voluntary organisations responded to these appeals in practice is less clear. Most surveys on asylum architecture have focused principally on the period prior to 1914.⁴¹ This has meant that subsequent twentieth-century additions and alterations are largely excluded; an omission that biases attention onto institutional planning, and away from adaptations that reflect changing therapeutic and social priorities.⁴² There are also still relatively few extensive case studies on early twentieth-century mental hospital treatment, and this small sample has perhaps resultantly revealed little coherence in planning for convalescence. Colney Hatch

⁴⁰ Jones, *Mental Health and Social Policy*, p. 106.

⁴¹ Jeremy Taylor, *Hospital and Asylum Architecture in England, 1840-1914: Building for Health Care* (London: Mansell, 1991); Christine Stevenson, *Medicine and Magnificence: British Hospital and Asylum Architecture, 1660-1815* (London and New Haven: Yale University Press, 2000); Susan Piddock, *A Space of their Own: The Archaeology of Nineteenth-Century Lunatic Asylums in Britain, South Australia and Tasmania* (New York: Springer Verlag, 2007).

⁴² Whyte, 'How Do Buildings Mean?', pp. 154-5, 172; Bridget Franklin, 'Hospital – Heritage – Home: Reconstructing the Nineteenth Century Lunatic Asylum', *Housing, Theory and Society* **19** (December 2002), pp. 170-1.

established a separate convalescent block as early as 1865, whilst Norfolk remained without any purpose-built admission or convalescent units a full century later.⁴³ Steven Cherry has suggested Norfolk's failure to build new units partially reflected broader economic pressures, yet in this respect it does not appear typical of other institutions.⁴⁴ Pamela Michael's study of Denbigh Mental Hospital focuses on one institution that did establish convalescent villas alongside other units between the wars.⁴⁵ Moreover, institutional case histories produced for a non-academic audience suggest that mental hospitals widely adapted and added convalescent units, often placed alongside dedicated admission hospitals.⁴⁶ These hint at broader changes to admission and convalescent facilities, which merit further attention for the affect they had upon mental hospital procedures.

Some historians have already contributed intriguing hypotheses and insights on the relationship between rebuilding and the therapeutic function

⁴³ Richard Hunter and Ida MacAlpine, *Psychiatry for the Poor, 1851-1973: Colney Hatch Asylum/ Friern Hospital, A Medical and Social History* (London: Dawson's, 1974), pp. 61-2; Cherry, *Mental Health Care in Modern England*, pp. 118-9, n.21. See Figure 1 for a plan of the convalescent home at Colney Hatch.

⁴⁴ Cherry, *Mental Health Care in Modern England*, pp. 173, 206.

⁴⁵ Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000* (Cardiff: University of Wales Press, 2003), p. 127.

⁴⁶ L. Thornhill, *History of Kingsway Hospital* (Derby, Derbyshire: Derby Area No. 4 Hospital Management Committee, c.1966, 2nd edition), pp. 34, 46; David Budden, *A County Lunatic Asylum: The History of St Matthew's Hospital, Burntwood* (Walsall: St Matthew's Hospital, 1989), pp. 98-9; Eric H. Pryor, *Claybury: A Century of Caring* (London: The Mental Health Care Group, Forest Healthcare Trust, 1993), pp. 78, 80; Tony Day, *More Like Home: The Story of Long Grove Hospital and How It was Closed to Improve Mental Health Services* (Hove: Pavilion, 1993), p. 22; David H. Clarke, *The Story of a Mental Hospital: Fulbourne, 1858-1983* (London: Process Press, 1996), p. 36; Adam Lamb and Jack Turton, *Behind the Walls: The Life and Types of Winterton Hospital* (Durham: Durham County, 1997), p. 34; Edward D. Myers, *A History of Psychiatry in North Staffordshire* (Leek: Churnett Valley, 1997), pp. 131-2; Malcolm Race, *A Century of Care: A History of St Luke's Hospital, Middlesborough* (Middlesborough: South Tees Community and Mental Health Trust, 1997), pp. 25-6; Andrew Bannister, *In Splendid Isolation: A Short History of the High Royds Hospital, the former West Riding Pauper Lunatic Asylum at Menston* (Leeds: Leeds Mental Health NHS Trust, 2005), p. 26. Elsewhere, asylums planned admission and convalescent units that were ultimately deferred until after World War Two, or simply abandoned. See John Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum / St John's* (London: Gaskell, 1990), pp. 142-3; Fay Crofts, *History of Hollymoor Hospital* (Studley, Warks: Brewin, 1998), p. 15.

of twentieth-century mental hospitals. Pamela Michael's description of the new admission, convalescent and nurses' units opened at Denbigh in 1934 as a 'new model hospital' has adopted the modernising language of those who promoted such accommodation. From this perspective, convalescent units formed part of a broader modernising agenda, in institutions primarily intended to care for and cure, rather than control, their resident populations.⁴⁷ The site, design and internal regulation of these buildings, however, distinguished them from others, and generated inequalities in the care offered to different patient groups. Provocatively, and in contrast to Michael, Vicky Long has emphasised the stigma placed on those in chronic and refractory wards, as a result of this selective focus on the potentially curable and almost-cured. Rather than a therapeutic step, therefore, Long has suggested that the separation of recoverable patients from the main asylum may have unwittingly diminished hope amongst residents in the older buildings.⁴⁸ Both Long and Michael therefore suggest how changes aimed at a minority of recent admissions and convalescent patients may have extended beyond these groups. It appears from this research, therefore, that material changes in convalescent accommodation altered the therapeutic dynamic of mental hospitals in ways unforeseen on their completion. Moreover, the stark differences in emphasis between these readings indicate singular changes in mental hospital design may have had multifarious consequences upon the operation of mental hospitals. Each change in mental hospital architecture, however localised, revised the relationship

⁴⁷ Michael, *Care and Treatment of the Mentally Ill*, p. 127.

⁴⁸ Long, 'Changing Public Representations of Mental Illness', p. 119.

between adjacent patient groups, as well as between re-housed patients and their immediate environment.

Such additions modified the spatial relationship between patient groups in ways that question Anne Rogers and David Pilgrim's conclusion that 1930s mental hospitals were essentially the 'same buildings but with a new treatment rhetoric'.⁴⁹ Certainly, Louise Westwood's research on out-patient clinics has supported the idea that the community offered a more attractive option for ambitious and innovative psychiatrists.⁵⁰ Shorter and Scull have likewise argued that asylum superintendents increasingly deserted mental hospitals in the 1920–30s for alternative fields of practice in the community.⁵¹ There remains an unresolved tension, however, between these claims that asylums remained little altered and widespread investment in new asylum facilities for convalescent and recent admissions in this period.⁵² Those involved with mental hospitals made bold claims for admission and convalescent units, which are jarringly inconsistent with the disillusionment Andrew Scull and Edward Shorter has perceived amongst medical superintendents in this period. The extent of therapeutic optimism or pessimism behind such additions is particularly explored in Chapters One and Two. From Michael and Long's different perspectives, it is possible to

⁴⁹ Anne Rogers and David Pilgrim, *Mental Health Policy in Britain: A Critical Introduction* (Basingstoke, Hants and London: Macmillan, 1996), pp. 62-3 Westwood, 'Avoiding the Asylum', p. 191.

⁵⁰ Westwood, 'Avoiding the Asylum', pp. 4, 159, 184; Louise Westwood, 'A Quiet Revolution in Brighton: Dr Helen Boyle's Pioneering Approach to Mental Health Care, 1899-1939', *Social History of Medicine* 14:3 (2001), p. 439.

⁵¹ Andrew Scull, *Decarceration: Community Treatment and the Deviant* (Cambridge: Polity Press, 1984), pp. 112-4; Andrew Scull, 'Psychiatry and Social Control in the Nineteenth and Twentieth Centuries', *Social History of Medicine* 2 (1991), p. 165; Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997), pp. 190-2.

⁵² Lindsay Prior, *The Social Organisation of Mental Illness* (London; Thousand Oaks, CA and New Delhi: Sage, 1993), pp. 29-30.

regard changes targeted at recoverable institutionalised patients as a curative measure or a cosmetic reconstruction that served professional and public agendas. More fundamentally, therefore, this thesis looks beyond the effect material changes may have had upon pathways to treatment, to assess the purpose these spaces were intended to serve.

The place of convalescence in connection with twentieth-century mental hospitals remains poorly understood, and still rests principally upon Erving Goffman's sociological interpretation put forward in *Asylums* (1961). In this analysis, Goffman has argued convalescent wards formed part of a broader 'ward system', which principally functioned to encourage behavioural conformity, rather than to reflect any underlying medical improvement. As a result, he has suggested that the label 'convalescents' corresponded with those who consciously adapted their behaviour, in contrast to others – potentially more sane – who refused to 'play...the system'.⁵³ Subsequent studies have applied Goffman's theories to an earlier generation of asylums, and have thereby primarily assessed convalescence from the perspective of institutional governance. Anne Digby has cited Goffman's theories, in her claim that the York Retreat implemented an early example of the 'ward system'. Like Goffman, Digby has suggested that the convalescent wards operated as one element within a system of rewards and punishments'.⁵⁴ In turn, Steven Cherry has suggested that convalescent wards included at the original Norfolk Lunatic Asylum in 1813 'rewarded' patients with the prospect of release. While Cherry has questioned the relevance of the term 'moral

⁵³ Erving Goffman, *Asylums: Essays in the Social Situations of Mental Patients and Other Inmates* (London: Penguin, 1991 [1961]), p. 121, 149-50.

⁵⁴ Digby, *Morality and Medicine*, pp. 66-7.

architecture' at Norfolk, he has nevertheless suggested that convalescent wards served to reinforce a sense of therapeutic advancement in patients' minds.⁵⁵ Andrew Scull has gone further, and suggested that imperatives of managerial control informed ward design across nineteenth- and twentieth-century asylums.⁵⁶ None of these historians has intended to look specifically at convalescence. Instead, they have interpreted its function within broader analyses of institutional classification and the moral influence this exerted over patient expectations and behaviour.

Goffman's analysis is most useful as a theory on the effect convalescence may have had upon patients, but suggests much less about the impulses that led to its practice. As Ian Hacking has argued, Goffman's methodology omitted any reflection on the 'formative structures' behind asylums and patient classifications.⁵⁷ Consequently, Goffman's work has provided little sense of what these institutions, and associated voluntary organisations in the community, intended when they offered convalescence to mental patients. In contrast, Michel Foucault's archaeological approach to the creation of spaces for the mad in the late eighteenth century postulates reasons for their emergence. Foucault has proposed that the York Retreat evolved 'as an instrument of segregation' and social control.⁵⁸ Applied to a later period, as attempted by Andrew Scull, this might suggest that convalescence had a subordinate and perhaps deceptive place in the asylum, as classification that pointed to imminent release, but actually

⁵⁵ Cherry, *Mental Health Care in Modern England*, p. 34; Digby, *Madness, Morality and Medicine*, pp. 67-71.

⁵⁶ Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979), pp. 120-1.

⁵⁷ Ian Hacking, 'Between Michel Foucault and Erving Goffman: Between Discourse in the Abstract and Face-to-Face Interaction', *Economy and Society* **33**:3 (2004), pp. 278, 288.

⁵⁸ Michel Foucault, *History of Madness* (London and New York: Routledge, 2006), p. 482.

formed part of a primarily carceral institution.⁵⁹ This presents a cogent theory for convalescence, as one classification amongst many, which formed the disciplinary mechanism for the control and management of the insane.⁶⁰ At the same time, however, neither Foucault nor Goffman set out to look at the early twentieth-century asylum in England. The arguments they make on power relations within mental hospitals – and its implications for convalescence – therefore rest on different cultural and historical contexts. Peter Bartlett in particular has suggested that nineteenth-century asylums operated with a far less centralised power base than Foucault has discerned in an earlier period.⁶¹ It is therefore desirable in the light of Bartlett’s critique to historicise the practice of convalescence in England, and consider where the impetus for its practice came from in historical context.

Any history of psychiatric convalescence must consider the place of convalescence beyond the mental hospital as well as its place within it. Efforts at restorative treatment were significantly constrained by the Lunacy Act of 1890, which made in-patient admissions to county asylums conditional upon legal certification. Only after the implementation of the Mental Treatment Act in 1931 could mental hospitals take patients on a purely voluntary or temporary basis. In the context of these legal constraints, it is perhaps unsurprising that several historians have interpreted early twentieth-century asylums as sites where an absence of suitably curable patients

⁵⁹ Scull, *Museums of Madness*, p. 120.

⁶⁰ Nikolas Rose, ‘Medicine, History and the Present’, in Colin Jones and Roy Porter (eds), *Reassessing Foucault: Power, Medicine and the Body* (London and New York: Routledge, 1994), pp. 57-61.

⁶¹ Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London and New York: Leicester University Press, 1999), p. 242.

impeded efforts at therapeutic experimentation.⁶² Since the 1980s, however, a succession of empirical studies have indicated that even under legal strictures, asylums returned significant numbers of patients to the community. These have implied that if mental hospitals remained stigmatised and stagnant sites of detention for many they also routinely discharged patients.⁶³ Graham Mooney and Jonathan Reinarz have further indicated that even amongst those not formally discharged, by the mid-nineteenth century many patients gained access to the community through parole or through contingent periods of release on trial, provided to test the extent of recovery.⁶⁴ By at least the same period, family visits, inspections and correspondence all gave institutionalised patients contact with the outside world.⁶⁵ Through an analysis of voluntary aftercare records, recently examined by Coleborne in Australian contexts, together with the records of mental hospitals themselves, this thesis considers how convalescence connected these institutions and their patients with the wider community.⁶⁶

Legislation recognised the distinct position convalescents occupied in the asylum, even if it also circumscribed the extent of care these institutions

⁶² Kathleen Jones, 'Law and Mental Health: Sticks or Carrots?', in German E. Berrios and Hugh Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Gaskell, 1991), pp. 95-6; Budden, *County Lunatic Asylum*, pp. 8, 86; Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), pp. 109-10; Fisher, 'Getting Out of the Asylum', p. 198.

⁶³ Laurence Ray, 'Models of Madness in Victorian Asylum Practice', *European Journal of Sociology* **22** (1981), pp. 233-4; Bartlett and Wright, 'Community Care and its Antecedents', pp. 3-4; Anne Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', in Jonathan Andrews and Anne Digby (eds), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004), pp. 117-8.

⁶⁴ Graham Mooney and Jonathan Reinarz, 'Hospital and Asylum Visiting in Historical Perspective: Themes and Issues', in Graham Mooney and Jonathan Reinarz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (Amsterdam and New York: Rodopi, 2009), pp. 13-16.

⁶⁵ Leonard Smith, "'Your Very Thankful Inmate": Discovering the Patients of an Early County Lunatic Asylum', *Social History of Medicine* **21** (September 2008), p. 250; Coleborne, *Madness in the Family*, pp. 131-4.

⁶⁶ Coleborne, *Madness in the Family*, pp. 139-41.

could offer. The Lunatics Act of 1845 made provision for asylums to discharge patients on a short-term period of trial leave, which allowed for probationary placement in the community under the terms of certification. Although the 1890 Lunacy Act restricted the period doctors could legally retain supervision over convalescent patients to twenty-eight days, interwar superintendents had several options for discharge. By the late nineteenth century the principle of temporary trial periods under the care of family or friends was well-established, and provided improved certified patients a period of care in the community, even whilst officially under asylum supervision.⁶⁷ From the 1880s asylums could also formally discharge patients as “recovered” and apply for their admission into the MACA’s cottage homes. This connected asylum practice with a system of voluntary social care in the community. Significantly, superintendents themselves took an increasingly active part in the MACA after 1900. In 1913, the MACA began to additionally accept trial patients, which allowed mental hospitals to place certified convalescents under organised convalescent care beyond their own walls, again subject to the MACA’s approval. The significance of trial has received insufficient attention, given it played such an important role in the transition many patients made from institutionalisation to the community.

There is consequently a need for more research on how convalescent practices reflected and promoted realignments in the relationship between mental hospitals to the community. Historians have increasingly challenged the idea that the power to discharge patients lay solely with asylums. A

⁶⁷ Fisher, ‘Getting Out of the Asylum’, pp. 85, 128; Smith, ‘Your Very Thankful Inmate’, pp. 240, 246.

diverse body of work has explored the input families, Poor Law officials, and the voluntary sector had in discharge practices. This scholarship has raised interesting questions over the influence community interests and activism may have exerted over institutional care and discharge practices.⁶⁸ Peter Bartlett in particular has shifted attention away from medical discourse that he has described as 'peripheral' to the primary function of asylums as part of a disciplinary Poor Law. Although Bartlett specifically excludes the twentieth century from his analysis, his arguments nevertheless situate the mental hospital in this period as the decedent of asylums that originated predominantly out of social concerns for the lunatic poor.⁶⁹ Any analysis on convalescence, particularly from the 1880s, must also extend beyond official lunacy administration, and further consider the voluntary sector. Mary Fisher in particular has challenged previous historical accounts that have argued the MACA occupied a relatively 'trivial' and traditional position in relation to official practices.⁷⁰ While this may be truer of the nineteenth century, after 1919 the MACA expanded significantly, developed new lines of activity, and forged stronger connections with superintendents and local authorities.⁷¹ Mary Fisher has further suggested patients' friends participated in discharge, though she has argued it became harder for these groups to exercise influence after the 1890s.⁷² Even so, Catherine Coleborne and Louise

⁶⁸ Coleborne, 'Challenging Institutional Hegemony'.

⁶⁹ Bartlett, *The Poor Law of Lunacy*, pp. 238, 243.

⁷⁰ Fisher, 'Getting Out of the Asylum', p. 14; Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (London; and New Haven, CT: Yale University Press, 1993), 321; William Parry-Jones, 'The Model of the Geel Lunatic Colony and Its Influence on the Nineteenth-Century Asylum System in Britain', in Andrew Scull (ed.), *Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era* (Philadelphia, PA: University of Philadelphia Press, 1981), p. 212.

⁷¹ Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services from the early Eighteenth Century to the 1990s* (London: Athlone, 1993), p. 128.

⁷² Fisher, 'Getting Out of the Asylum', pp. 137, 198, 224.

Wannell have indicated they also influenced care through negotiating trial and improved conditions for institutionalised relatives.⁷³

Recuperative procedures and discharge arrangements are therefore likely to have emanated from the community as well as the institution. Because convalescence spanned institution and community, its practice invited wider participation than other phases of organised mental treatment. Voluntary convalescence undoubtedly depended significantly upon the cooperation and support of local authorities and medical superintendents, and therefore some commonality of interest. Nevertheless, it is possible to discern a range of medical and social impulses behind the practice of convalescence. The official, social, and familial interests in asylum discharge raised in Bartlett, Fisher, and Coleborne's research hints at potentially rival concerns behind convalescence. In line with Bartlett's arguments, Vicky Long has suggested the MACA's cottage homes served a utilitarian function. As such, Long has argued that convalescence served to morally restore the idle convalescent to useful employment, and economically save taxpayers the burden of the public maintenance in the process.⁷⁴ This broadly corresponds with Bartlett's representation of the asylum system generally as an 'economy of choices', which served to encourage or coerce the patient to socially-acceptable modes of behaviour.⁷⁵ In marked contrast, however, Jennifer Cronin has found that many families and patients in the general medical sector looked on convalescence as a form of rest and holiday. As such,

⁷³ Coleborne, 'Challenging Institutional Hegemony', pp. 289-90; Catharine Coleborne, 'Families, Insanity, and the Psychiatric Institution in Australia and New Zealand, 1860-1914', *Health and Place* 11:1 (2009), p. 77; Louise Wannell, 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910', *Social History of Medicine* 20 (September 2007), 297-313.

⁷⁴ Long, 'Public Representations of Mental Illness', pp. 185, 191-2, 221.

⁷⁵ Bartlett, *Poor Law of Lunacy*, pp. 246-7.

Cronin has indicated that recipients and their advocates defined convalescence as a *lack* of work, whilst Steven Cherry and Vicky Long have argued many workers increasingly saw it as an entitlement.⁷⁶ Far from the disciplinary system Bartlett and Long have alluded to, Cronin's research suggests convalescents and their advocates may have viewed their place in institutional treatment as consumers, rather than Foucauldian 'docile bodies'. These contested viewpoints raise questions over the extent to which broader social agendas influenced the provision and acceptance of convalescence, and over the degree of agency recipients felt in the latter stages of recovery.

It is possible to see the expansion of provision for mental convalescence as part of a broader interwar concern with borderline psychiatric conditions. Roy Porter has contended that the popularisation of psychological theory, and research into community mental health, betrayed a gradual 'eating away' of distinctions between sickness and wellness in the interwar period.⁷⁷ Subsequent research has lent credence to Porter's proposition that psychiatry expanded to occupy new borderlands in the community. Studies on child guidance and suburban neurosis, for example, have suggested how psychiatrists and social workers problematised and pathologised the home as a site for mental wellbeing.⁷⁸ At the same time, research on the Industrial

⁷⁶ Cronin, 'Scottish Convalescent Homes', pp. 1-2, 211-14; Steven Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996), p. 73; Vicky Long, *The Rise and Fall of the Healthy Factory: The Politics of Industrial Health in Britain, 1914-60* (London and New York: Palgrave Macmillan, 2011), pp. 112-3.

⁷⁷ Roy Porter, 'Two Cheers for Psychiatry!: The Social History of Mental Disorder in Twentieth-Century Britain', in Hugh Freeman and German Berrios (eds), *150 Years of British Psychiatry Volume II: The Aftermath* (London: Athlone, 1996), p. 393.

⁷⁸ Kathleen W. Jones, "'Mother Made Me Do It': Mother-Blaming and the Women of Child Guidance', in Molly Ladd-Taylor and Lauri Umansky (eds), *"Bad" Mothers: The Politics of Blame in Twentieth-Century America* (London and New York: New York University Press, 1998), p. 101; John Stewart, "'I Thought You Would Want to Come and See His Home": Child Guidance and Psychiatric Social Work in Inter-War Britain', in Mark Jackson (ed.), *Health and the Modern Home* (Abingdon, Oxon; and New York: Routledge, 2007), pp. 111,

Health Research Board, and Industrial Welfare Society, has suggested that the workplace also became the target for preventive and remedial health practices, notably to combat occupational psychoneuroses.⁷⁹ While these problems were targeted in the community, other newly-classified groups such as the feeble-minded, and shellshocked, received new purposely-designed institutions for their management.⁸⁰ Taken together, this research prompts questions over what prompted some borderline patients to gain institutional treatment, while others were treated and targeted in the community. This thesis investigates these issues by looking at one group of patients – convalescents – whose position relative to institution and society was especially ambiguous. Typically, historians have tended to look for innovations in interwar psychiatric practice outside the asylum. Out-patient clinics, the Maudsley Hospital, psychotherapy, and mental hygiene certainly provided a new focus for psychiatric practice.⁸¹ Yet the relationship between these departures and developments in mental hospital practice – particularly over those at the borderland between sickness and health – require closer examination. Accordingly, this thesis considers how the creation and

118-9; Rhodri Hayward, 'Housewives, Neuroses, and the Domestic Environment in Britain, 1945-70', in Jackson (ed.), *Health and the Modern Home*, pp. 43, 46-7.

⁷⁹ A.J. McIvor, 'Manual Work, Technology, and Industrial Health, 1918-39', *Medical History* **31** (1987), 160-89; Vicky Long and Hilary Marland, 'From Danger and Motherhood to Health and Beauty: Health Advice for the Factory Girl in Early Twentieth-Century Britain', *Twentieth Century British History* **20** (October 2009), pp. 459-61.

⁸⁰ Mark Jackson, *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Late Victorian and Edwardian England* (Manchester and New York: Manchester University Press, 2000), p. 11; Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c. 1870-1959* (Oxford: Oxford University Press, 1998), pp. 117-20; Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (Basingstoke, Hants: Palgrave Macmillan, 2002), pp. 121-42.

⁸¹ Scull, 'Psychiatry and Social Control', p. 162; Westwood, 'Avoiding the Asylum'; Edgar Jones, Shahina Rahman, and Robin Woolven, 'The Maudsley Hospital: Design and Strategic Direction, 1923-1939', *Medical History* **51** (July 2007), p. 357.

expansion of convalescence within mental hospitals reflected wider concerns over the prevention and maintenance of mental health in the community.

Seen from this perspective, the history of convalescence has much to reveal about the emergence of community care. Mathew Thomson has already indicated that the term 'community care' was applied in the 1920s to the residential treatment of mental defectives. This has prompted Thomson, amongst others, to question how far it formed part of a 'hidden history' of early twentieth-century psychiatric care in the community.⁸² Convalescence offered a different approach to community care from that Thomson has described, however, as a practise that aimed to consolidate the type of recovery largely excluded from the notion of congenital mental deficiency. This is not to deny that similar theories of care-giving may have informed both approaches; my research contributes in this respect to a broader body of scholarship that explores the origins and nature of moves to place mental disorder in more familiar social contexts. Nonetheless, the imperatives that underpinned the long-term care of congenital mental disorder are certainly likely to have diverged significantly from the short-term remedial care offered to convalescents. Like Thomson, some, like Douglas Bennett, Hugh Freeman, and Kathleen Jones have already suggested that the MACA's cottage homes represented a prototypical form of community care, after they first opened in the 1880s.⁸³ How far local authority mental hospitals

⁸² Mathew Thomson, 'Community Care and the Control of Mental Defectives in Inter-War Britain', in Horden and Smith (eds), *The Locus of Care*, p. 199; Peregrine Horden, 'Household Care and Informal Networks: Comparisons and Continuities from Antiquity to the Present', in Horden and Smith (eds), *The Locus of Care*, pp. 28-9; Louise Westwood, 'Care in the Community of the Mentally Disordered: The Case of the Guardianship Society, 1900-1939', *Social History of Medicine* 20:1 (2007), p. 71.

⁸³ Douglas Bennett, 'The Drive Towards the Community', in German E. Berrios and Hugh Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Gaskell, 1991), p. 323;

participated in these developments merits further investigation. While Andrew Scull has argued the MACA remained 'trivial' to official practices before 1900, others have indicated it forged notably strong links with the London County Council (LCC) in particular after 1919.⁸⁴ Moreover, it appears that a few local authorities at least may have incorporated such voluntary convalescence as a standard part of their mental hospital procedures, and in so doing, contributed to the history of early community care.

Patients' views on mental treatment are often difficult to trace, but are nevertheless important to a rounded historical conception of what the term meant, and the various functions it served. Catharine Coleborne has recently implored historians to pay more attention to the 'emotional responses' institutionalised patients exhibited during their confinement.⁸⁵ More specifically, Cronin has also called for more work on patient attitudes to convalescence.⁸⁶ Such attention to patient perspectives is important, because it indicates social interpretations of the latter stages of recovery, and their commensurability with medical concepts of convalescence. Different interpreters described convalescence in noticeably distinct ways and associated the term with a constellation of connotations.⁸⁷ As such, the coherence detectable between the various patient, family, voluntary, and medical interpretations of convalescence reflects the term's conceptual vitality in interwar discourses. The extent to which these groups shared a

Hugh Freeman and Douglas Bennett, 'Origins and Development', in Douglas H. Bennett and Hugh L. Freeman (eds), *Community Psychiatry* (London: Churchill Livingstone, 1991), pp. 41-2; Jones, *Asylums and After*, p. 128.

⁸⁴ Roof, *Voluntary Societies and Social Policy*, pp. 23-4, 118-9; Jones, *Asylums and After*, p. 128.

⁸⁵ Coleborne, 'Families, Insanity, and the Psychiatric Institution', p. 74.

⁸⁶ Cronin, 'Scottish Convalescent Homes', pp. 275, 283, 285.

⁸⁷ Hacking, *The Social Construction of What?*, pp. 31-4.

common understanding of convalescence has wider repercussions, because it illuminates the degree to which they shared agreement over the purposes of institutional treatment. Historians have utilised a variety of sources, including patient accounts, casebooks and visitation records, in order to interrogate intersubjectivity between patients, families, and asylums. This work has suggested such groups had opportunities for regular dialogue, and may have contributed to continually contested perspectives on clinical identity and belonging.⁸⁸ As an overtly transitional phase designed to bridge institution and community, convalescence offers a particularly significant and hitherto little-considered thematic entry point into the comparability of medical and social perspectives on recovery.

Historians of psychiatry have widely unseated the asylum as the sole locus of psychiatric care-giving. Monographs and collections such as Bartlett and Wright's *Outside the Walls of the Asylum* (1999) have illustrated the important role family homes may have served as a dominant, if largely undocumented, domicile for the mentally disordered.⁸⁹ Such studies have also suggested that family carers may have strategically utilised institutions in times of crisis. This work has therefore correlated admission and discharge data with the ability of families to cope economically and emotionally with their mentally disordered relations. Building upon John Walton's earlier notion that families 'cast out' and (more rarely) 'brought back' members, the work of Wright, Akihito Suzuki, and Mary Fisher

⁸⁸ Beveridge, 'Life in the Asylum'; Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine* 11 (June 1998), 255-81; Smith, 'Your Very Thankful Inmate'; Coleborne, 'Families, Insanity, and the Psychiatric Institution'.

⁸⁹ Bartlett and Wright, 'Community Care and Its Antecedents', in Bartlett and Wright (eds), *Outside the Walls of the Asylum*, pp. 1-18; Suzuki, *Madness at Home*, pp. 3-4; Horden and Smith, *The Locus of Care*; Coleborne, *Madness in the Family*, pp. 59-60.

suggests that those in the community may have pragmatically and proactively exploited institutional care.⁹⁰ Less clear, as Coleborne has surmised, is how patients and families responded emotionally to these transitions.⁹¹ Coleborne's research forms part of a small number of case studies that have begun to explore the bond between families and their insane relatives, and attachments to asylum and home. Collectively, these authors have illustrated that these groups maintained an independent and critical perspective on treatment regimes, even if these views were various and sometimes inconsistent. Lay representations of convalescence are especially interesting, because they suggest how far patients wanted to return home immediately after asylum treatment, and to a lesser extent how far families encouraged this. Historians have highlighted the limited evidence within traditional asylum sources on the lives and experiences of patients before admission and after discharge.⁹² This makes those records on individual experiences of convalescence all the more valuable, as evidence of how at least one subset of institutional patients may have felt about their identity and belonging.

3. Methodology and Sources

⁹⁰ John Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-70', in W.F. Bynum, Roy Porter and Michael Shepherd (eds), *Madness: Essays in the History of Psychiatry, Volume II: Institutions and Society* (London: Tavistock, 1985), pp. 132-46; Suzuki, *Madness at Home*, p. 64; David Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine* 10:1 (1997), pp. 142, 150-1; Fisher, 'Getting Out of the Asylum', pp. 19-20, 137, 224.

⁹¹ Coleborne, 'Families, Insanity, and the Psychiatric Institution', p. 74.

⁹² Bartlett, *Poor Law of Lunacy*, p. 249; Andrews, 'Case Notes, Case Histories, and the Patient's Experience', p. 263; Bartlett and Wright, 'Community Care and Its Antecedents', pp. 2-3; Coleborne, *Madness in the Family*, p. 123.

This thesis approaches the meaning and significance of convalescence within the mental hospital system through three central dynamics, suggested in the foregoing historiography. At the centre of each of these strands is a concern to identify the reasons why convalescence occupied an increasingly prominent and publicly-acknowledged place in interwar mental hospitals.

Firstly, this thesis considers the architectural position set aside for convalescence as one of several classificatory divisions within the mental hospital itself. It considers how these environments functioned to place convalescents at the threshold of freedom, and informed their relationship with other patient classifications, the mental hospital, and wider society. Such reflections include consideration of how convalescent units corresponded with a concern for the public and professional image of the asylum as alternately curative or custodial institutions. The second dynamic explored relates to the procedural connections forged between mental hospitals and agencies in the community during a patient's convalescence, whether families, voluntary organisations, or the general public. This speaks to the broader intersection between social and professional interests in mental recovery and discharge, and the position mental hospitals themselves occupied in the community. Thirdly and finally, this thesis examines the relationship between classifiers and the classified – between those who identified patients as convalescents and the patient themselves – and the extent to which these groups shared a mutual understanding over what the term meant. This thesis consequently assesses the meanings and relevance of convalescence as a widely-applied category, through the contested

interpretations of those who created, supervised or received convalescence within these homes.

To provide context on the place of convalescence in the mental hospital system, Chapter One looks at the origins of convalescent provision, from the 1780s through to 1939. References to convalescence in the history of psychiatry are generally brief, and only rarely has its meaning been clearly defined. The chapter therefore addresses the changing definition of convalescence over a broad period, in order to establish precedents for the issues associated with the practice after 1919. This draws upon contemporary published books and journal articles that dealt with the place convalescent patients should occupy with the ideal mental hospital, and the reasons for their separate treatment. As such, it looks at professional discourse, in order to assess whether medical superintendents and architects reached a consensus over the functions of convalescence within the asylum. Chapter Two then turns to consider the spatial arrangement of the convalescent villa. This examines the reasons behind the BoC's strident insistence that such units should be added to public mental hospitals and the therapeutic, professional and managerial functions they served. Because Jeremy Taylor has accredited the LCC's asylums with introducing detached villas in England, the chapter looks particularly at the origin and development of convalescent villas at this authority and the factors that influenced their design.⁹³

⁹³ Taylor, *Hospital and Asylum Architecture in England*, p. 152; Jeremy Taylor, 'The Architect and the Pauper Asylum in Late Nineteenth-Century England: G.T. Hine's 1901 Review of Asylum Space and Planning', in Leslie Topp, James E. Moran, and Jonathan Andrews (eds), *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (Abingdon, Oxon and New York: Routledge, 2007), p. 276.

Chapter Three transfers attention onto community-based convalescent homes provided through the MACA and similar charities for the mentally disordered. It looks at the nature of these charities' interests in environment, regimen and sociability, and what this reveals about the intended purpose of additional convalescence outside mental hospitals. A further case-study on the LCC is incorporated in this chapter, based on Madeline Roofff and Kathleen Jones's observations that this authority maintained notably strong links with the MACA.⁹⁴ While London undoubtedly played an important role in the development of new approaches to convalescence, this chapter also considers other distinct local approaches to aftercare in areas such as Bristol and Brighton. BoC inspection reports provide useful clues to these regional differences, which are otherwise difficult to ascertain without extensive multiregional analysis, though they point to the desirability of further detailed case studies. Chapter Four analyses patient and familial responses to convalescence, predominantly through the MACA's case records, to assess recipients' and friends' interpretations of its uses. The first part of this chapter explores methodological issues associated with patient narratives and case records. These insights are thereafter applied to an analysis of patient representations of recovery, which considers the significance of convalescence within individual narratives of psychiatric improvement. Finally, this chapter assesses how patients reacted in practice when offered convalescence, and what this suggests about their choices over care and place in society.

⁹⁴ Roofff, *Voluntary Societies and Social Policy*, pp. 116-9; Jones, *Asylums and After*, p. 128.

This thesis focuses solely on the place of convalescence in relation to mental hospitals, and therefore excludes other recuperative practices primarily intended for those recovering from somatic illness. Convalescent institutions for the mentally ill shared certain functional similarities with those for the somatically sick. All these homes provided a temporary break of up to around three months, and were intended to shield incipiently-well patients from unfavourable influences that might precipitate renewed illness.⁹⁵ Indeed, general convalescent homes at least partly inspired the development of comparable voluntary cottage homes for mentally ill convalescents in the 1880s.⁹⁶ Their emergence closely paralleled the development of other institutions, designed to maximise therapeutic exposure to fresh air, sunshine and restful environments.⁹⁷ Indeed, the similarities between tuberculosis sanatoria and convalescent homes in some cases led to the two terms being used interchangeably in the late nineteenth and early twentieth century.⁹⁸ Pivotaly, however, and despite superficial similarities, homes for mental convalescence addressed a qualitatively distinct problem from somatic convalescence, firmly rooted in an asylum-based approach to recovery.⁹⁹ This centred on the threat environmental and societal pressures posed to patients' emotional stability, and their ability to form functional occupational

⁹⁵ Cronin, 'Scottish Convalescent Homes', pp. 1-3, 118.

⁹⁶ In 1871 and again in 1879, the founder of the Mental After-Care Association, Henry Hawkins, partly justified his arguments for dedicated mental convalescent homes on the grounds that existing general convalescent homes would be unlikely to take ex-asylum patients. See Henry Hawkins, 'A Plea for Convalescent Homes in Connection with Asylums for the Insane Poor', *Journal of Mental Science* **17** (April 1871), 109-10; Henry Hawkins, 'After Care', *Journal of Mental Science* **24** (October 1879), p. 362.

⁹⁷ Jeffrey Reznick, 'Rest, Recovery, and Rehabilitation: Healing and Identity in Great Britain in the First World War' (Emory University, unpublished PhD thesis, 1999), pp. 69-70; Jeffrey Reznick, *Healing the Nation: Soldiers and the Culture of Caregiving in Britain during the Great War* (Manchester: Manchester University Press, 2004), pp. 43-4.

⁹⁸ Bignall, *Frimley*, pp. 6, 15, 18.

⁹⁹ Asylums had their own independent tradition of convalescent care from the late eighteenth century, which is explored in Chapter One.

and domestic relationships in the wider world. Whereas somatic convalescence remedied bodily indisposition, mental convalescence had to target the psychiatric and social dispossession associated with mental hospital treatment, and the place of its former residents in wider society. The convalescent homes studied in this thesis consequently deal with specific issues on the effects of stigma, kinship networks, and survival in society, to some extent specific to mental illness.

Previous work in asylum history has tended to concentrate particularly on developments before 1914. As this thesis explores, however, it was most notably after 1919 that convalescence came to occupy a new place in the mental hospital, and beyond in the community, even if this model often derived from earlier pre-war experiments. As Chapters Two and Three demonstrate, the period after 1919 is significant in its own right, for the expansion in both onsite mental hospital convalescent villas, and offsite voluntary cottage homes. Moreover, as Chapter Three evidences, the period from the 1910s witnessed a significant alteration in the relationship between the MACA and the LCC, which fundamentally altered convalescent care in the metropolis. This all took place in the particular contexts of interwar mental hospital practice, which as Chapters One and Two explore, witnessed unprecedented public and official interest in asylum administration. While this thesis contemplates the impact of World War One on civilian convalescence, it largely omits provision for ex-servicemen, due to essential differences in the origins and imperatives of care for these patients. Ex-servicemen received separate recuperative care in their own right through the Ministry of

Pensions and associated charities.¹⁰⁰ Jeffrey Reznick has identified a public image of heroism with convalescent ex-servicemen, which is in marked contrast to the stigmatisation associated with the mental hospital system explored in this thesis.¹⁰¹ Whilst Chapters Two and Four suggest the civilian mental patient arguably enjoyed a relatively higher status during convalescence, their position in society and consequently the implications of their ongoing care were likely to have diverged significantly from that of ex-servicemen.

The thesis ends in 1939, when the war emergency forced the suspension of building on mental hospital convalescent villas and a renewed concern for the particular issues of mental illness in wartime. It is possible to overstate the dislocation of war: the MACA would write in its annual report that despite the 'unavoidable interruption' of war, its homes remained in use, while mental hospitals often resumed internal building work later in the 1940s and 1950s.¹⁰² Nevertheless, war also seems to have encouraged new developments in social psychiatry and psychiatric rehabilitation, which merit separate consideration in their own right.¹⁰³ War temporarily disrupted routines and the type of normality that convalescence sought to provide its patients. In turn, it potentially created opportunities for reform and reconstruction and change as well as continuity, which future studies could usefully further explore.

¹⁰⁰ Leese, *Shell Shock*, pp. 131-42.

¹⁰¹ Reznick, *Healing the Nation*, pp. 100-12.

¹⁰² WLHUM, MACA, SA/MAC/B.1/1-51, Annual Reports, 1939, pp. 4-5.

¹⁰³ Michael Neve, 'A Commentary on the History of Social Psychiatry and Psychotherapy in Twentieth-Century Germany, Holland and Great Britain', *Medical History* **48** (October 2004), p. 409; Prior, *Social Organisation of Mental Illness*, p. 63; Ena Elsey, 'The Rehabilitation and Employment of Disabled Ex-Servicemen after Two World Wars' (unpublished PhD thesis, University of Teeside, 1994), pp. 89-95.

Comparisons between countries in the management of residential care for the mentally ill highlight the local and cultural dimensions that informed access to convalescence and understandings of recovery. Arrangements for further support for the recently improved varied significantly between countries. Thus, in contrast to negligible provision for aftercare in countries such as Spain, other countries such as England, France and Australia, all provided access to some form of structured follow-up support.¹⁰⁴ It is notable that there also were significant differences between these countries. Thus, while the London-based MACA remained strictly secular, the French charity sheltered convalescents from 1840 within a religious community.¹⁰⁵ The Australian After-Care Association's boarding-out arrangements as described by Catharine Coleborne sounds much closer to the MACA's, which is perhaps unsurprising, given the early correspondence conducted between these organisations.¹⁰⁶ The availability of convalescence in different national contexts, is likely to have depended to a significant extent upon the prevalence of institutional care, and related systems for the probationary removal of convalescents. Where countries like Scotland, Belgium and the US had a system of boarding-out in place, patients already occupied a home-like environment during their treatment. Boarding-out provided patients with a place in the community, which perhaps to some extent offered an alternative to the post-institutional 'half-way house' of convalescence. Indeed, the Lunacy (Scotland) Act of 1857, which permitted the boarding-out of lunatics for up to six months, enforced the

¹⁰⁴ Oscar M. Azumendi, 'Asylum and the Community in Spain', in John Carrier and Dylan Tomlinson (eds), *Asylum in the Community* (London and New York: Routledge, 1996), p. 31.

¹⁰⁵ Robert Jones, 'The After-Care Association for Befriending Persons Discharged from Asylums for the Insane', *Journal of Mental Science* **53** (July 1906), p. 624.

¹⁰⁶ Coleborne, *Madness in the Family*, p. 140. See also Chapter Three.

same cap of four patients per home that the MACA established as the optimum number in its own cottage homes.¹⁰⁷ Legal and cultural conditions in Scotland thus differed markedly from countries such as England and Australia, which relied more heavily upon shorter-term probationary trial leave to supervise patients in the community.¹⁰⁸

It is due to these divergent national contexts that this thesis focuses specifically on convalescence in England. Future work might fruitfully compare cultures of recovery across international boundaries, but it is also important to recognise the distinctive cultural conditions that informed regional variations in its practice and theory. Recent studies have indicated the extent to which psychiatric ideas crossed political frontiers, but have also raised the dangers inherent in assuming equivalence between concepts in different social settings.¹⁰⁹ Martin Powell and Pamela Michael have noted the particularities in Welsh social and cultural contexts, which, in common with Scotland, included a stronger tradition of private domestic care for the mentally ill.¹¹⁰ The focus on England in this thesis acknowledges such

¹⁰⁷ The Act permitted the retention of patients under boarding-out for up to six months. This was double the three month maximum typically applied to convalescents in the MACA's homes, though where mental hospitals transferred patients to these from their own onsite convalescent accommodation, the cumulative time spent under 'convalescence' may have been considerably longer. See also Chapter Three. Tom Walmsley, 'Psychiatry in Scotland', in German E. Berrios and Hugh Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Gaskell, 1991), p. 301.

¹⁰⁸ Coleborne, *Madness in the Family*, p. 142.

¹⁰⁹ Mathew Thomson, 'Mental Hygiene in Britain during the First Half of the Twentieth Century: The Limits of International Influence', in Volker Roelcke, Paul J. Weindling, and Louise Westwood (eds), *International Relations in Psychiatry: Britain, Germany and the United States to World War II* (Woodbridge, Suffolk; and Rochester, NY: University of Rochester Press, 2010), pp. 137, 151.

¹¹⁰ Michael has identified a greater reliance on home care for the insane. In contrast to English counties, she has found institutional treatment for the insane only became widespread in Wales from c.1900. Such national trajectories suggest potentially different contexts for the creation and use of 'half-way homes' for convalescents in England and Wales. The different traditions in the role of asylums and the domestic sphere in mental treatment are likely to have influenced how convalescent institutions were intended to function as 'half-way homes' (see Chapter One). See Michael, *Care and Treatment of the*

regional specificities, even though there is evidence that in south Wales at least, there was some overlap with English aftercare. Wales fell under the same legal and administrative jurisdiction as England, and therefore in many respects formed part of the same entity. Besides a unitary official system of lunacy administration across England and Wales (which included a central Board of Control, and shared recommendations in official reports), Cardiff also had its own branch of the MACA by 1920. Nevertheless, nuances of social and cultural geography across Wales as a whole, and the absence of voluntary cottage homes for convalescents into the late 1920s, make it a sufficiently separate case to warrant independent study.¹¹¹ Scotland was still more distinct, as it maintained its own system for boarding-out under the 1857 Act, regulated through an independent General Board of Control. Still further from the highly-centralised MACA and its convalescent homes in south-east England, Scotland – like Wales – deserves its own case-study.¹¹²

Regional differences are also highly apparent and have informed my methodological approach. This is based predominantly on a case-study of the LCC's mental hospitals. Several authors have explored the high status the LCC enjoyed in the interwar period for its healthcare provision. All have

Mentally Ill, pp. 2-5; Martin Powell, 'What Was Wales?: Towards a Contextual Approach to Medical History', in Pamela Michael and Charles Webster (eds), *Health and Society in Twentieth-Century Wales* (Cardiff: University of Wales Press, 2006), p. 217; Pamela Michael, 'Welsh Psychiatry during the Interwar Years, and the Impact of American and German Inspiration and Resources', in Volker Roelcke, Paul J. Weindling, and Louise Westwood (eds), *International Relations in Psychiatry: Britain, Germany, and the United States to World War II* (Rochester, NY and Woodbridge, Suffolk: Rochester University Press, 2010), p. 197.

¹¹¹ The Cardiff branch of the MACA briefly sent patients to the MACA's cottage homes in the south-east of England, but had stopped this practice by 1926, when Edwin Goodall (Medical Superintendent, Cardiff City Mental Hospital) observed that 'we want our own cottage homes and our organisations'. See *Minutes of the Royal Commission on Lunacy and Mental Disorder*, p. 743, ref. 17,265.

¹¹² This is particularly the case as Jenny Cronin's thesis on general convalescent homes in Scotland provides a useful point for comparison in a single national context. See Cronin, 'Scottish Convalescent Homes'.

to some extent supported the idea that the LCC was perceived, and with some justification, as a progressive authority.¹¹³ London appears to have been particularly central to the development of asylum convalescent services. In contrast to the poor connections between the LCC's municipal hospitals and voluntary hospitals, the LCC maintained exceptionally close links with the voluntary MACA.¹¹⁴ The location of these homes in the south-east of England not only made them accessible from the charity's Westminster offices, but further made them particularly convenient for London's mental hospitals. Moreover, the LCC further assumed a particularly prominent role in the development and support of new voluntary convalescent services, as Chapter Three explores.¹¹⁵ London's mental hospitals also implemented some of the earliest detached convalescent blocks, including the first 'villas' set aside for this purpose.¹¹⁶ As such, the development of convalescence in England appears to have been earliest and most comprehensive in London.¹¹⁷ At the same time, however, the BoC's annual reports in particular have indicated that some asylums opted to develop their own local convalescent services, sometimes in innovative

¹¹³ John Sheldrake, 'The LCC Hospital Service', in Andrew Saint (ed.), *Politics and the People of London: The London County Council, 1889-1965* (London and Ronceverte, WV: Hambledon, 1989), pp. 185, 193; Mathew Thomson, 'Social Policy and the Management of the Problem of Mental Deficiency in Inter-war London', *London Journal* **18**:2 (1993), p. 129; Martin Powell, 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History* **8**:3 (1997), pp. 337-8; John Stewart, "'The Finest Municipal Hospital Service in the World?': Contemporary Perceptions of the London County Council's Hospital Provision, 1929-39', *Urban History* **32**:2 (2005), pp. 331-4, 342.

¹¹⁴ Stewart, 'Finest Municipal Hospital Service in the World?', pp. 339-40; Roof, *Voluntary Societies and Social Policy*, pp. 23, 116.

¹¹⁵ Roof, *Voluntary Societies and Social Policy*, pp. 116-9; Jones, *Mental Health and Social Policy*, p. 106.

¹¹⁶ Hunter and MacAlpine, *Psychiatry for the Poor*, pp. 61-2; Taylor, 'The Architect and the Pauper Asylum', p. 276.

¹¹⁷ John Sheldrake's references to a 'general shortage' of convalescent beds in London's interwar general hospitals suggests the extent of development may not have been uniformly spread, however, across different areas of London's healthcare services. See Sheldrake, 'LCC Hospital Service', p. 192.

ways.¹¹⁸ While the focus of the analysis is on London, therefore, this thesis also investigates approaches in other areas, where these shed light on alternative approaches to convalescence.

Consequently, this thesis focuses upon the reasons for the practice of mental convalescence as a practice in interwar England, particularly in London. It uses quantitative data to assess the extent of this growth, but thereafter primarily applies a qualitative analysis to organisational records, journals and patient case-notes and autobiographies to assess what purposes mental convalescent homes served to those who planned, managed or utilised them. This compares the spatial organisation of convalescent units captured in plans and photographs with descriptions of their function in official, local authority, voluntary and patient records, to assess the intentions behind their design and placement, and subsequent reinterpretation amongst occupants and visitors. An alternative approach to the development of such (at least partially) community-based approaches to treatment might quantitatively compare the timing and location of new forms of convalescence with the extent of overcrowding and budget allocations.¹¹⁹ The qualitative evidence examined in this thesis suggests that both these issues may have affected the pace and degree of change to convalescent accommodation between 1919 and 1939, and merit further investigation beyond the scope of this study. Some use is made of the MACA's financial

¹¹⁸ Chris Philo and John Pickstone have partly illustrated their point that innovations in psychiatry often emerged in unlikely locations, by pointing to the development of detached convalescent accommodation at Devon Asylum in the 1840s. See Chris Philo and John Pickstone, 'Unpromising Configurations: Towards Local Historical Geographies of Psychiatry', *Health and Place* **15** (September 2009), p. 900.

¹¹⁹ For an example of this approach see Alysa Levene, Martin Powell, and John Stewart, 'Patterns of Municipal Health Expenditure in Interwar England and Wales', *Bulletin of the History of Medicine* **78** (Fall 2004), 635-69.

records and statistical data in annual reports to determine the timing and origins of growth, particularly in relation to the LCC. Brief analysis of patient gender ratios, suicides, and relapses hints at the importance of convalescence as a factor in the determination of the future lives of patients. This thesis listens to the voices of those who participated in its practice to answer a central question: where did the interwar mental convalescent and those buildings used to care for them belong in mental institutions and society?

Chapter One: The Development of Accommodation for Convalescents in Asylums and Mental Hospitals, c.1780–1939

1. Introduction

Between c.1780 and 1939, asylum planners proposed a diverse range of wards, blocks and villas for convalescent patients. As this chapter explores, little consensus over their arrangement emerged until the early twentieth century, although convalescence itself had a long association with the asylum system. Over the late eighteenth and nineteenth centuries innovations often arose from local experimentation at asylums widely scattered across the country. Thus, institutions in Yorkshire, Devon and Lancashire all adopted novel approaches to convalescent accommodation, and exemplify Chris Philo and John Pickstone's point that advances often arose in 'unlikely' locations.

¹ After c.1900, however, this appears less true, as London increasingly pioneered a paradigm of convalescent care that the central government lunatic authorities would attempt to impose on all authorities after 1919. The extent and reasons for widespread official and local authority support for convalescent villas in the interwar period are examined in more detail in Chapter Two. To provide the context for this discussion, the present chapter considers the origins and lineage of mental hospital convalescence, in the medical and architectural writings of those who originally planned these institutions. In particular, it focuses on published guidance on asylum construction and conversion, found in a range of books, official circulars and

¹ Chris Philo and John Pickstone, 'Unpromising Configurations: Towards Local Historical Geographies of Psychiatry', *Health and Place* **15** (2009), p. 900.

reports, and journal articles. From the 1850s, the *Journal of Mental Science* in particular provided a specialist forum for professional debate amongst alienists and architects on institutional planning, and provides a notably rich source on contemporary attitudes.

Such evidence is utilised in the chapter to answer two related questions: firstly, how did asylum planners conceptualise convalescence, and, secondly, what place did their view of convalescence have within their broader plans for the ideal asylum? Consequently, it seeks to address why convalescence had such a long association with the asylum, through analysis of asylum planning that situates convalescence functionally within a broader scheme of institutional design. This chapter is divided into three chronological sections, which broadly correspond with three phases in the history of asylum convalescence.

While subsequent chapters will explore the varied perspectives that different interpreters held of convalescence between 1919 and 1939, this chapter considers how one group reconceptualised it over a broader period, from c.1780 to 1939. Historians have begun to explore the compromises that informed institutional design. Chris Philo, for example, has identified compromises in nineteenth-century asylum planning between a desire to facilitate centralised supervision and a concern to separate patients by classification.² This dilemma embodies the same sort of tension between repression and rehabilitation that Anne Digby has identified in the eighteenth-

² Chris Philo, 'Scaling the Asylum: Three Geographies of the Inverness District Lunatic Asylum (Craig Dunain)', in Leslie Topp, James E. Moran, and Jonathan Andrews (eds), *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (Abingdon, Oxon; and New York: Routledge, 2007), p. 117.

century design of the York Retreat.³ In both their studies, Philo and Digby have raised the existence of distinct spaces for convalescence that placed their residents in a specific relationship relative to the asylum and the wider community. Asylum planners continuously balanced competing imperatives for where such improved patients should belong, for these and other reasons explored in this chapter.

Section One considers the early development of asylum planning to 1853 in the work of asylum planners such as Samuel Tuke, W.A.F. Browne, and John Conolly, whose books contributed a range of propositions on the desirability and utility of convalescence. Section Two covers the period between 1853 and 1898, when it became possible for asylum planners to compare and contrast their ideas amongst peers following the publication from 1853 of the *Journal of Mental Science (JMS)* as a common forum for professional discussion on the ideal asylum. It considers the reasons for the considerable diversity in approaches to convalescence in the late nineteenth century. The final section examines the era of the convalescent villa, first introduced into England with plans for Bexley Asylum in 1898, and thereafter extended to other asylums, especially after 1919. While Chapter Two concentrates on the utility of these villas within interwar central and local government policy, the present chapter focuses on their conceptual origins, and the place convalescence more generally occupied within the asylum.

³ Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), p. 85.

2. Moral Architecture and Convalescence, c.1780–1853

The York Retreat casts a long shadow over the history of asylum planning in England, and consequently over the place convalescents occupied within these institutions. Opened in May 1796 for Quaker patients, William Tuke's vision of moral therapy at the Retreat introduced an interpersonal and spiritual approach to mental improvement into a planned therapeutic environment. Treatment at the Retreat centred on a Quaker belief that mad and sane alike maintained an 'inner light' of self-restraint, which could be influenced through an environmental and interpersonal appeal to the emotions.⁴ To promote behavioural conformity, and prevent aberrant thoughts and actions, the Tuke family designed the Retreat to provide patients with healthful surroundings, combined with the sympathetic tutelage of fellow believers. Despite the highly specific doctrinal basis for Tukean moral therapy, historians have widely perceived the Retreat as a blueprint for subsequent asylum planning. Barry Edington and Roy Porter have claimed that the Retreat caused alienists to regard asylum design itself as a therapeutic agent in rehabilitation. While Porter has argued it legitimated the 'idea that asylums were right for the mad', Edington has proposed that the Retreat set a precedent for a much closer attention to asylum design in the nineteenth century.⁵ Instances of this architectural genealogy are raised in the work of Jeremy Taylor and Ida MacAlpine and Richard Hunter. These

⁴ Louis Charland, 'Benevolent Theory: Moral Therapy at the York Retreat', *History of Psychiatry* **18** (March 2007), 61-80.

⁵ Roy Porter, *Mind Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (Cambridge, MA: Harvard University Press, 1987), pp. 158, 225, 227-8; Barry Edington, 'Moral Architecture: The Influence of the York Retreat on Asylum Design' *Health and Place* **3** (June 1997), p. 91; Barry Edington, 'A Space for Moral Management: The York Retreat's Influence on Asylum Design', in Leslie Topp, James E. Moran, and Jonathan Andrews (eds), *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (London: Routledge, 2007), pp. 88-9.

authors have collectively identified the Retreat's influence in subsequent asylums built at Nottingham (opened 1812), Lancaster (1812–17), Wakefield (1816–18), Hanwell (1829–31), as well as other institutions outside England.⁶

Indeed, Barry Edington has gone further to propose that the Retreat continued to directly inspire prominent asylum architects into the early twentieth century.⁷ At least some asylum planners recognised themselves as heirs to Tukean principles, such as R.H. Steen, who claimed in 1900 that the Retreat had heralded a 'new era' in mental treatment.⁸ Yet it is important to distinguish what precisely about the York Retreat inspired subsequent generations of asylum planners and the extent to which the Retreat originated a new approach to convalescence. Some historians have suggested that the Retreat inceptioned the first dedicated classification that separated patients according to their behaviours and diagnoses.⁹ Nevertheless, Christine Stevenson has indicated that as early as 1783 Bethlem utilised its attics for the 'safer sorts' of patients.¹⁰ In 1788 John Howard visited Bethlem and criticised the open lines of communication between patients on different floors, which Andrew Scull has suggested

⁶ Ida MacAlpine and Richard Hunter, 'Introduction', in Ida MacAlpine and Richard Hunter (eds) *Description of the Retreat* (London: Dawsons, 1964), pp. 19-23; Jeremy Taylor, *Hospital and Asylum Architecture in England, 1840–1914: Building for Health Care* (London: Mansell, 1991), pp. 134-5.

⁷ Barry Edington, 'The Well-Ordered Body: The Quest for Sanity through Nineteenth-Century Asylum Architecture', *Canadian Bulletin of Medical History* 11:2 (1994), p. 383; Barry Edington, 'The Design of Moral Therapy at the York Retreat', *Journal of Design History* 16 (April 2003), p. 108.

⁸ In 1900, Steen was Senior Medical Officer at West Sussex Asylum, and continued to write on asylum planning into the interwar period, most notably in *The Modern Mental Hospital* (1927). R.H. Steen, 'The Evolution of Asylum Architecture, and the Principles which Ought to Control Modern Construction', *Journal of Mental Science* 46 (January 1900), p. 88.

⁹ John D. Thompson and Grace Goldin, *The Hospital: A Social and Architectural History* (London and New Haven: Yale University Press, 1975), pp. 71-4; Andrew Scull, *Social Order/ Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (Berkeley and Los Angeles: University of California Press, 1989), p. 225.

¹⁰ Christine Stevenson, 'The Architecture of Bethlem at Moorfields', in Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker, and Kier Waddington (eds), *The History of Bethlem Hospital* (London and New York: Routledge, 1997), p. 236.

indicates that 'segregation of inmates... was largely ignored in the eighteenth century [asylum]'.¹¹ Stevenson's research, however, would suggest that Bethlem had attempted such segregation by this date, while Howard's expectation that Bethlem ought to divide manic and placid suggests the idea of classification was already well established. At least some asylums implemented rudimentary classification in the decade prior to the Retreat's inception. George Dance the Younger designed a remodelled St Luke's Hospital in 1786 to include a separate day-room for female convalescents to practice needlework.¹² So too, John Ferrier at Manchester Asylum would claim in the mid-1790s that he had long hoped to devote a room for 'convalescents [as a]... reward of regular behaviour'.¹³

It is possible, therefore, to see the Retreat's approach to classification set out in Samuel Tuke's *Description of the Retreat* (1813) and *Practical Hints* (1815) less as a departure, than as an elaboration and extension of existing principles. Tuke's books helped publicise the Retreat's approach to a wider audience, both to contemporary asylum planners (*Practical Hints* was dedicated to the architects of the future Wakefield Asylum) and to posterity. Successive generations of asylum planners claimed their indebtedness to Tuke's writings, from John Conolly and Robert Gardiner-Hill (1830–40s) and J.T. Arlidge (1850s) to G.T. Hine (1890–1900s).¹⁴ The attention these

¹¹ Scull, *Social Order/ Mental Disorder*, p. 225.

¹² Leonard Smith, *Lunatic Hospitals in Georgian England, 1750-1830* (London and New York: Routledge, 2007), pp. 152-3.

¹³ John Ferrier, *Medical Histories and Reflections, volume II* (London: Cadell and Davies, 1795) in Richard Hunter and Ida MacAlpine (eds), *Three Hundred Years of Psychiatry, 1535-1860* (London: Oxford University Press, 1963), p. 546; Digby, *Madness, Morality and Medicine*, pp. 66-7.

¹⁴ Robert Gardiner Hill, *A Concise History of the Entire Abolition of Mechanical Restraint in the Treatment of the Insane* (London: Longman, Brown, Green and Longmans, 1857), p. 251; Camilla M. Haw, 'John Conolly and the Treatment of Mental Illness in Early Victorian

authors gave to the Retreat reflects its influence on nineteenth-century planning, yet also obscures the antecedents of its classificatory system in other institutions. Tukean classification primarily grouped patients according to their department. In this respect, the Retreat's approach differed little from that taken at earlier asylums such as Leicester and Manchester. At Leicester (1794), the 'peaceful and manageable' were housed separately from the 'violent, untractable, or shocking' [*sic*], whose difference was therefore adjudged from their outward conformity to behavioural conventions.¹⁵ In 1795, the year before the Retreat opened, John Ferrier similarly adjudged patients according to their conduct when he proposed that admission to a convalescent ward should act as a 'reward of regular behaviour'.¹⁶ Patients at the Retreat were similarly grouped according to their outward responses, with convalescents placed alongside others capable of 'common enjoyment', such as the 'best melancholics'. Consequently, Tukean classification followed the model established at earlier asylums, which separated patients primarily according to the degree of their derangement rather than their prognosis.¹⁷

Nevertheless, convalescents at the Retreat do appear to have obtained access to certain spaces, and benefited from certain privileges, which increasingly identified them as a class apart. Most notably in 1811 the Retreat established a separate home for convalescents at Walmgate Bar at the gates to the city of York. Its position symbolically placed the convalescent

England', *Psychiatric Bulletin of the Royal College of Psychiatrists* **13** (1989), p. 442; Edington, 'Moral Architecture', p. 92.

¹⁵ Smith, *Lunatic Hospitals in Georgian England*, p. 151.

¹⁶ Ferrier, *Medical Histories*, in MacAlpine and Hunter, *Three Hundred Years of Psychiatry*, p. 546.

¹⁷ Samuel Tuke, *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums* (York: William Alexander, 1815), p. 18.

patient at the portal to civic life, and, Anne Digby has argued, allowed these patients to 'participate in [its]... normal patterns'.¹⁸ This paralleled further efforts within the main Retreat building to provide convalescents with a more socially normative existence. Occupational therapy was originally intended for the 'curable and convalescent', which allowed those with the best prognoses to utilise the space of the Retreat more purposefully and less passively.¹⁹ Such targeted treatment was also extended to convalescents' leisure activities, which in turn allowed access into parts of the institution closed to other inmates. They could use the dining room, and thereby share a space otherwise exclusive to the superintendent's family and patients of a higher class. This encouraged the convalescent to enter an area otherwise restricted on the basis of rationality and social rank, and therefore distinguished them from others of similar capacity for 'common enjoyment'. Tuke overtly made a connection between this privilege, and the promotion of recovery.²⁰ Unlike other patients convalescents could leave the Retreat and visit or sometimes stay with friends in the community. Later, in 1827, pleasure grounds were laid out for female convalescents, creating an additional space for these patients to roam beyond the Retreat and exercise some independence.²¹ Consequently, liberty of movement rather than permanent attachment to any one building seems to have distinguished convalescents within the Retreat.

The significance of the Appendage appears to lay in the precedent it established for later halfway homes, rather than its contemporary

¹⁸ Digby, *Madness, Morality and Medicine*, p. 45.

¹⁹ *Ibid.*, p. 63.

²⁰ Samuel Tuke, *Description of the Retreat* (York: William Alexander, 1813), p. 99

²¹ Digby, *Madness, Morality and Medicine*, pp. 56, 69.

innovativeness in convalescent treatment. Certainly, the extended liberty it offered to convalescents established a template for later homes, and extended the liberal regime offered to these patients within the main Retreat building and grounds. However, Digby has suggested that convalescent patients proved reluctant to move there and leave the main Retreat; a conclusion the patient responses to proffered convalescence explored in Chapter Four partly echoes. Instead, its managers filled the home with chronic cases, and finally in 1822 closed it and moved all residents back to apartments in the central block.²² Little commitment therefore existed at this stage for dedicated convalescent accommodation. Despite its short life, the Lunacy Commission's reference to the Appendage in 1855 as an experiment for a 'limited number of convalescent patients' does suggest it had an influence beyond its short life.²³ By this stage, other asylums such as Leicester had already begun to add detached convalescent units, which the Lunacy Commission in 1856 would commend for the 'greater degree of liberty' they offered the most recovered patients.²⁴ In turn, this report would influence others such as J.T. Arlidge's (1859) plans for detached convalescent blocks, which therefore indirectly revived a model of accommodation pioneered at the Retreat fifty years earlier.²⁵

In the intervening period, several early nineteenth-century asylum planners had experimented with different arrangements of wards and blocks, to better differentiate patients according to gender, social rank, and the

²² *Ibid.*, p. 45.

²³ *Ibid.*; British Parliamentary Papers Online, *Copy of the Ninth Report of the Lunacy Commission to the Lord Chancellor* (London: H.M. Stationary Office, 1855), p. 72.

²⁴ Lunacy Commission, *Annual Report*, 1856, pp. 27-8.

²⁵ J.T. Arlidge, *On the State of Lunacy and the Legal Provision for the Insane with Observations on the Construction and Organization of Asylums* (London: J. & A. Churchill, 1859), pp. 142-3.

outward manifestations of their illness. These bore some similarity to the compartmentalised plan of seven discreet blocks opened at the Quaker Edward Long Fox's exclusive Brislington House, near Bristol, in 1804. Fox's design is significant to the history of asylum convalescence, principally because it established a clear and visible separation between different types of patient within the grounds of the asylum itself. Classification at Brislington House differed little from other early nineteenth-century institutions for the mad. Like the Retreat, Brislington House distinguished patients primarily by gender, then a combination of social status and behaviour. In common with other asylums, therefore, convalescents resided alongside other tranquil patients, and in contradistinction to the 'noisy, dirty or violent'.²⁶ Although Fox's classification appears relatively conventional for asylums in this period, his introduction of detached blocks permitted an unusually high degree of separation between these groupings. Furthermore, Brislington House and the Retreat also established a connection between environment and recovery, through gardens, airing courts and planned walks that brought patients into therapeutic contact with the natural world.²⁷ Windows and doors in these blocks therefore respectively provided patients with visual and physical access to the surrounding landscape.²⁸ The degree of separation established across Brislington House in 1804, and at the Retreat's Appendage in 1811, allowed greater choice over the extent and nature of the contact afforded to residents in different blocks. If convalescents remained

²⁶ Leonard Smith, 'A Gentleman's Mad-Doctor in Georgian England: Edward Long Fox and Brislington House', *History of Psychiatry* **19** (2008), pp. 170, 178.

²⁷ Clare Hickman, 'Cheerful Prospects and Tranquil Restoration: The Visual Experience of Landscape as Part of the Therapeutic Regime of the British Asylum, 1800-60', *History of Psychiatry* **20** (December 2009), p. 429; Edington, 'Moral Architecture', p. 92.

²⁸ Edington, 'The Well Ordered Body', pp. 180-3; Tuke, *Description of the Retreat*, p. 98.

broadly grouped with other well-behaved patients in these institutions, they nevertheless established the means for more differentiated convalescent care amongst subsequent generations of asylum planners.

The influence of French alienist Jean-Etienne-Dominique Esquirol was perhaps even more significant in the development of early nineteenth-century convalescent accommodation. Whereas the Retreat and Brislington House both placed convalescents and tranquil patients together, Esquirol treated convalescence as a distinct phase in recovery. In 1802, Esquirol had opened a private asylum in Paris, opposite the much larger Salpêtrière asylum run by his mentor, Philippe Pinel. This provided convalescents with a distinct home, separated absolutely from the main asylum by planned gardens. Moreover, Dora Weiner has argued that the orientation of the home towards the Museum of Natural History was purposefully intended to allow residents to visit exhibits, and thereby participate in social life.²⁹ While the Appendage would similarly place convalescents symbolically at the gateway to civic participation, unlike the Retreat's managers, Esquirol would remain committed to the separation of convalescents from other patients. It is this concern for the specific needs of the convalescent that made Pinel and Esquirol so influential in British asylum planning. Some, like the asylum inspector Sir Alexander Morison, privately documented Esquirol's approach to classification; others, like James Cowles Prichard and W.A.F. Browne went on to publicly advocate his ideas. Thus, Morison visited Esquirol in 1818 and noted in his diary Esquirol's plans for a new asylum with separate

²⁹ Dora Weiner, 'Esquirol's Patient Register: The First Private Psychiatric Hospital in Paris, 1802-1808', *Bulletin of the History of Medicine* **63** (Spring 1989), p. 111.

sections and exercise grounds for both male and female convalescents.³⁰

Such ideas were disseminated further in the alienist James Cowles Prichard's *A Treatise on Insanity* (1835), which advocated both Pinel's separation of the tranquil from the convalescent, and Esquirol's provision of dormitories for the exclusive use of convalescents.³¹

W.A.F. Browne in *What Asylums Were, Are, and Ought to Be* (1837) engaged more extensively with Esquirol's proposals than either Morison or Prichard. The series of blocks Browne proposed resembled those Fox had earlier planned for Brislington House, yet he claimed inspiration instead from Esquirol's relocated asylum, which had moved to Ivry in the Paris suburbs in the 1820s. In particular, Browne praised the balance Esquirol had managed between the convenient distribution of buildings, with the high degree of separation between buildings for convalescent and tranquil and those for the disorderly.³² Together with fellow Scotsman Morison and Scottish-educated Prichard, Browne therefore looked to France for his ideas on classification, particularly with regards to convalescence. Thus, Browne contrasted 'France [where] convalescent wards exist in almost every asylum' with the failure of British asylums to recognise the 'propriety of such an arrangement'.³³

Andrew Scull has speculated that Browne's prioritisation of French over British moral therapy was 'political' and intended to privilege Pinel and

³⁰ Ibid.; Alexander Morison, 'Diary', in Richard Hunter and Ida MacAlpine (eds), *Three Hundred Years of Psychiatry, 1535-1860* (London: Oxford University Press, 1963), p. 738.

³¹ Prichard's indebtedness to French thought can be gauged from the fact he dedicated the book to Esquirol in his preface. James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (London: Sherwood, Gilbert and Piper, 1835), pp. 303-4; Ian Lodge Patch, 'The Surrey County Lunatic Asylum (Springfield): Early Years in the Development of an Institution', *British Journal of Psychiatry* **159** (1991), p. 71.

³² W.A.F. Browne, *What Asylums Were, Are, and Ought to Be* (Edinburgh: Adam and Charles Black, 1837), p. 221.

³³ Ibid., p. 154.

Esquirol's medical training, over the indigenous Quaker approach of Tuke.³⁴ In opting to emphasise French moral therapy, Browne, Morison and Prichard all identified convalescence as a more distinct category in its own right than at the Quaker-inspired York Retreat and Brislington House. The language Browne used to describe insanity left the reader in little doubt that it was a medical illness or that mental convalescents needed specialist and specific care. His comparison between the asylum convalescent and the 'man recovering from fever' formed part of an argument for 'removal' of convalescents on the lines practised at general hospitals. Based further on the example of French asylums, Browne therefore set out an agenda for more targeted convalescent treatment that aimed specifically to prevent a 'renewal of the disease'.³⁵

John Conolly's first book, published in 1830, had described the convalescent in similarly specific and medical terms, yet offered a strikingly different prescription for their care. Like Browne, Conolly's *Inquiry Concerning the Indications of Insanity* compared mental convalescence with 'convalescence from a lingering fever'.³⁶ General hospitals in both England and Scotland had established Samaritan societies for charitable aftercare, and, as Browne and Conolly's comparisons attested, provided separate care for certain patients in remission. An increasing interest in the preservation and promotion of health in general medicine is evident in both the introduction of the word 'sanatorium' into general English usage (1839), and

³⁴ Andrew Scull, *The Asylum as Utopia: W.A.F. Browne and the Mid-Nineteenth Century Consolidation of Psychiatry* (London and New York: Tavistock and Routledge, 1991), p. lxvii.

³⁵ Browne, *What Asylums Ought to Be*, p. 154.

³⁶ John Conolly, *An Inquiry Concerning the Indications of Insanity with Suggestions for the Better Regulation and Care of the Insane* (London: John Taylor, 1830), p. 23.

in the material provision made for convalescents at the first dedicated home in the country (1840).³⁷ Yet while Browne and Conolly may have shared a wider concern for the fate of convalescent patients, they disagreed over the therapeutic role asylums could perform. Browne argued that the properly designed asylum could and should take an active part in convalescence, and provide these patients with the 'gentle and strengthening treatment bestowed on infancy'. Consequently, Browne idealised this asylum as a refuge, which, although preferably close to the social life of the town, nevertheless affected cure primarily through careful supervision, judicious classification, and a country environment.³⁸ In contrast, Conolly questioned whether asylums might actually produce insanity and provoke relapses amongst convalescents, though he would substantially renounce this conclusion in the 1840s. Thus, he challenged 'anyone who has ever seen the interior of a lunatic asylum' to question whether the conversations and behaviours on display would lead the 'poor convalescent... back to wise and happy thought'.³⁹ Whereas Browne, as Claire Hickman has suggested, presented the asylum as the 'only... apparatus to cure insanity', Conolly suggested that in convalescence, it might instead act to *cause* insanity.⁴⁰

³⁷ The term 'sanatorium' is first recorded in England in the *London Medical Gazette* (1839). J.R. Bignall has suggested that the word 'sanatorium' at this stage fulfilled a function broadly equivalent to the convalescent home, as a 'place of healing... of returning to health'. The first dedicated general convalescent home – the Metropolitan Convalescent Institution – opened at Walton-on-Thames in 1840. J.R. Bignall, *Frimley: The Biography of a Sanatorium* (London: Seven Corners, 1979), p. 6; Oxford English Dictionary Online, 'Sanatorium' (Oxford: Oxford University Press, 1989, 2nd edition), available at <http://www.oed.com/view/Entry/170455?redirectedFrom=sanatorium#>

³⁸ Browne, *What Asylums Ought to Be*, pp. 199-200.

³⁹ Conolly, *Indications of Insanity*, pp. 25-26.

⁴⁰ Clare Hickman, 'Vis Medicatrix Naturae: The Design and Use of Landscapes in England for Therapeutic Purposes since 1800' (unpublished PhD thesis: University of Bristol, 2006), p. 90.

Trial leave and parole offered a means for the further separation of convalescents from other patients. Leonard Smith has indicated that asylums such as Gloucester already operated temporary trial leave to test the fitness of patients for final discharge from the 1820s onwards.⁴¹ Others, such as John Conolly and Edward James Seymour (Physician; previously Metropolitan Commissioner in Lunacy, 1830–38), would equally advocate the removal of convalescents from the asylum immediately prior to their discharge. Because Conolly felt the asylum might retard improvement, he recommended that convalescents should be allowed out of the asylum for exercise with appropriate supervision.⁴² Seymour went further in 1847, and, like Samuel Hitch at Gloucester before him, supported the entire removal of the convalescent patient from the asylum in the latter stages of their treatment. Whereas some like James Cowles Prichard (1835) warned against the threat premature discharge might cause to convalescents' health, Seymour instead argued earlier discharge could actually promote improvement.⁴³ Thus, Seymour claimed that he had observed several cases where trial had a 'beneficial effect', and in some cases he felt convalescents' restoration to society had directly resulted in their 'restoration to reason'.⁴⁴ Planners fundamentally disagreed, therefore, over the respective influence institutions and wider society might have upon convalescents' hopes for stable improvement. Whereas Browne and Prichard envisaged the properly subdivided asylum as a potential safeguard against institutional and social

⁴¹ Leonard Smith, "'Your Very Thankful Inmate": Discovering the Patients of an Early County Lunatic Asylum', *Social History of Medicine* 21:2 (2008), p. 240.

⁴² Conolly, *Inquiry Concerning the Indications of Insanity*, pp. 488-9.

⁴³ Prichard, *Treatise on Insanity*, p. 291.

⁴⁴ Edward James Seymour, *Thoughts on the Nature and Treatment of Several Severe Diseases of the Human Body, Volume I* [1847], in Richard Hunter and Ida MacAlpine (eds), *Three Hundred Years of Psychiatry, 1535–1860* (London: Oxford University Press, 1963), p. 963.

causes of relapse, those such as Seymour, Hitch and (early) Conolly contrarily regarded re-entry into wider society as a beneficial aid to improvement.

Alongside the emergence of convalescence as a fundamental category in psychiatric classification, the 1830s also mark the point at which asylum planners increasingly began to define what set convalescents apart. In particular, it is possible to locate the origins of a recurrent debate on the respective threat to convalescents, posed on the one hand by the medically-managed yet still potentially maddening asylum, and on the other by often sympathetic but unskilled community interests. It is important not to overstate the differences between Browne and Conolly's perspectives on convalescence. Both accepted that the asylum could aid recovery with sufficiently rigorous classification. So too, Conolly shared Browne's view of convalescence as a medical category, and similarly held some regard for the importance of skilled supervision and directed exercise during this phase of treatment.⁴⁵ However, Conolly in 1830 placed much more emphasis than Browne on both the risks the asylum posed to sustained improvement, and the extent to which an engagement with life beyond the main institution might promote recovery. Conolly's prescription of walks outside, lay visitation, and seclusion from other inmates during convalescence all suggested that health depended upon liberty and sociability with the sane.⁴⁶ In contrast, Browne presented asylum convalescent wards and (for the 'well-educated and well-bred convalescent') co-residence with staff as the main instrument in cure.⁴⁷

⁴⁵ Conolly, *Indications of Insanity*, pp. 23-4.

⁴⁶ *Ibid.*, pp. 29, 483, 487-9.

⁴⁷ Browne, *What Asylums Ought to Be*, p. 202.

For Browne and others, such as Prichard, therefore, the asylum represented the best hope for successful convalescence. These contested readings on the source of relapse helped further define convalescence, as a phase of treatment that required special planning, to militate against both societal and institutional causes of relapse.

In turn, however, therapeutic optimism and administrative pragmatism, in each case encouraged the disappearance or occlusion of convalescence as a target for separate treatment. Even within the short career of individual asylum planners and their asylums, the emphasis on distinct convalescent accommodation could differ markedly. Robert Gardiner Hill would later praise the steps Dr Charlesworth had initially made to improve classification at Lincoln Asylum between 1821 and 1827, before he had allowed a 'retrograde movement' that allowed mixed patients (including convalescents) to share the same wards.⁴⁸ Under Hill's superintendence, however, men and women had a 'convalescent apartment' by 1838. In little over a decade, therefore, convalescents gained, lost, and regained a clearer sense of separation from others, even in this one asylum.⁴⁹ In practice, Susan Piddock has suggested that overcrowding frequently forced co-residence between different classifications.⁵⁰ Such institutional compromises perhaps partly explain why John Conolly in 1847 rescinded his arguments for the isolation and re-socialisation of convalescents. In *Construction and Government of Lunatic Asylums* (1847), Conolly candidly admitted that it proved 'scarcely possible

⁴⁸ Hill, *Concise History of the Abolition of Mechanical Restraint*, pp. 253-4.

⁴⁹ *Ibid.*, pp. 152, 154-5; Robert Gardiner Hill, *Total Abolition of Personal Restraint in the Treatment of the Insane* (New York: Arno Press, 1977 [1838]), pp. 22, 30, 39.

⁵⁰ Susan Piddock, *A Space of their Own: The Archaeology of Nineteenth-Century Lunatic Asylums in Britain, South Australia and Tasmania* (New York: Springer Verlag, 2007), pp. 128, 135.

to have one ward which is perfectly free from occasional disturbance'.⁵¹ Beyond such pragmatism, however, it is evident that Conolly was by this date more comfortable with the idea that convalescents might share wards not only with each other, but also with other tranquil cases and some recent admissions.⁵² Influenced by Hill's approach to non-restraint at Lincoln, Conolly now regarded the potential for cure at asylums more favourably, and, perhaps in consequence, accepted that convalescents could mix with other patients. In an apparent return to the optimism of the York Retreat (which had also influenced Conolly's approach to non-restraint), Conolly classified patients primarily according to their quietude.⁵³

Early nineteenth-century asylum planners therefore established the principle that convalescence was a distinct category, yet arrived at no consensus over the place it should occupy in the asylum. Where John Conolly and W.A.F. Browne disagreed in the 1830s over how to manage convalescents as a distinct category, others – including Conolly himself – at other times suggested no such dedicated treatment was necessary. Like Conolly, Maximilian Jacobi in his *Construction and Management of Hospitals for the Insane* (1841) revised his earlier views on convalescent classification.⁵⁴ Both authors appear to have modified their opinions based on practical experience. Whereas Conolly had admitted he had found strict classification impractical, Jacobi noted that 'as a result of observations', he regarded any claims that convalescents needed strict separation to be 'the

⁵¹ John Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (London: Dawsons, 1968 [1847]), p. 19.

⁵² *Ibid.*, p. 18.

⁵³ Haw, 'John Conolly', p. 442.

⁵⁴ Samuel Tuke, 'Introduction', in Maximilian Jacobi, *On the Construction and Management of Hospitals for the Insane* (London: John Churchill, 1841), p. xxv.

mere chimeras of theorists'.⁵⁵ Samuel Tuke tacitly agreed in his introduction, which drew readers' attention to Jacobi's plans for distinct asylum apartments that would accommodate the least severely afflicted patients, 'whether strictly convalescent or not'.⁵⁶ Such views differed markedly from Prichard and Browne's recent assertions on the liability of relapse, unless convalescents could occupy dormitories or blocks exclusively set aside for their recoveries. Despite the variability of asylum planners' responses to the needs of asylum convalescents, however, it is nonetheless notable that between c.1780 and 1853 the category was regularly incorporated into considerations on the form of the ideal asylum. Moreover, the separate wards, dormitories, blocks and external homes proposed and built in this period established precedents for many of the solutions to convalescent accommodation attempted in subsequent decades.

3. Contested Sites of Convalescence and the 'Barrack' Asylum, 1853–1898

The development of professional journals and textbooks from the 1850s made it increasingly possible for asylum planners to address a discreet professional audience and moreover respond rapidly to emergent ideas.⁵⁷ Whereas previously, authors such as John Conolly had consolidated their thoughts in larger treatises and only after several years (if at all) revised their viewpoints, from the 1850s a clearer exchange of ideas becomes discernible.

⁵⁵ Jacobi, *Construction and Management*, p. 57.

⁵⁶ Tuke, 'Introduction', in Jacobi, *Construction and Management*, p. xxvii.

⁵⁷ The *Asylum Journal for Mental Science* first appeared in 1853. John Bucknill produced the first psychiatric textbook in 1858, which would run through a further three editions by 1879. See Andrew Scull, Charlotte MacKenzie and Nicholas Hervey, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, NJ and Chichester, West Sussex: Princeton University Press, 1996), p. 188.

The inception in 1853, of what would become (in 1858) the *JMS*, in particular, provided a regular forum for English asylum planners to contest their ideas on the ideal layout of the asylum. Chris Philo has concluded that articles published in the *JMS* between 1853 and 1862 represented no 'single institutional blueprint'.⁵⁸ Despite increasing uniformity in planning, such as a movement in favour of cottage and pavilion asylums that several historians have identified, these blueprints showed little uniformity over the appropriate place for convalescence.⁵⁹ Some like the architect George Bibby (1889) failed to mention convalescence at all, in highly centralised plans that placed all patients relatively close to central supervision; in contrast, others like John Bucknill from the 1850 to the 1870s would propose a complete separation of convalescents into cottages, and even into the wider community. Such proposals necessarily had to consider the wider contexts of institutional planning and in particular a legacy of older buildings. American physician Thomas Kirkbride summed up the problem in 1854 when he complained that many 'lamentable defects' could 'scarcely be remedied without actually rebuilding the hospital, at considerable cost'.⁶⁰ Consequently, after the 1840s and 1850s asylum planners increasingly questioned how far it was necessary or possible to nurture convalescents, within inherited asylums that

⁵⁸ Chris Philo, "Enough to Drive One Mad": The Organisation of Space in Nineteenth-Century Lunatic Asylums', in Jennifer Wolch and Michael Dear (eds), *The Power of Geography: How Territory Shapes Social Life* (Boston and London: Unwin Hyman, 1998), p. 283.

⁵⁹ Jeremy Taylor, *The Architect and the Pavilion Hospital: Dialogue and Design Creativity in English, 1850-1914* (London and New York: Leicester University Press, 1997), p. 129; Andrew Scull, 'A Convenient Place to Get Rid of Inconvenient People: The Victorian Lunatic Asylum', in Anthony D. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London; Boston; and Henley, Oxon: Routledge & Kegan Paul, 1980), p. 53.

⁶⁰ Thomas Kirkbride, 'Remarks on the Construction, Organization and General Arrangements of Hospitals for the Insane', *American Journal of Insanity* 11:1 (July 1854), p. 3.

some claimed were too obsolescent and overcrowded to fulfil their intended purpose.

The County Asylums Act, 1845, required all regions to provide asylums, but authorities continued to build and extend asylums into the twentieth century. Such expansion led some, like private asylum proprietor J.T. Arlidge, to question how far centralised asylum wards could provide an adequately therapeutic environment for mental recovery.⁶¹ Deriding the three-fold growth in asylum inmates between 1843 and 1857, Arlidge proposed a limit of 300 inmates per institution and a design that incorporated domestic and homely features.⁶² At the time Arlidge was writing in 1859, however, the average size of county asylums was around 450 beds; this would rise to nearly 1,000 beds by 1899–1901.⁶³ Over the same forty years, the total asylum population in England and Wales nearly quadrupled, creating a substantial architectural legacy of extensions, additions and entirely new institutions.⁶⁴ Although in a minority, not all asylum planners agreed that larger asylums necessarily threatened patients' therapeutic prospects. Joseph Lalor in 1860 welcomed institutional expansion.⁶⁵ So too, in 1859 C. Lockhart Robertson planned in advance for 'inevitable' future

⁶¹ Arlidge had earlier worked under Conolly at Hanwell, before he became resident superintendent at St Luke's Hospital in 1846, and would subsequently in 1858 become the proprietor of Kensington House. See 'Obituary: John Thomas Arlidge', *British Medical Journal* (4 November 1899), p. 1325; Nicholas Hervey, 'The Lunacy Commission, 1845-60, with Special Reference to the Implementation of Policy in Kent and Surrey' (PhD thesis, University of Bristol, 1987), p. 218; Edward D. Myers, 'J.T. Arlidge (1822–1899): A Disillusioned Alienist?', *Psychiatric Bulletin of the Royal College of Psychiatrists* **19** (1995), p. 770.

⁶² Arlidge, *On the State of Lunacy*, pp. 139, 203.

⁶³ The average number of beds in county asylums rose from 463 beds (1859–61) to 1,027 (1899–1901). Moreover, these figures concealed wide disparities between different counties. Whilst the smallest throughout this period proved comparable to Arlidge's ideal number of 300 patients, the largest held in excess of 1,000 patients, rising to more than 2,500 by the end of the period. Lunacy Commission, *Annual Reports*, 1860-2, 1900-2.

⁶⁴ Lunacy Commission *Annual Report*, 1900, p. 8.

⁶⁵ Joseph Lalor, 'Observations on the Size and Construction of Lunatic Asylums', *Journal of Mental Science* **7** (October 1860), p. 106.

enlargement, which he suggested might actually prompt improvements.⁶⁶

Eight years later, Robertson contended that an asylum with 600 beds 'will be in most points be better organised.... than a smaller one of 300'.⁶⁷ This claim directly contradicted Arlidge's case for smaller asylums and hints at a broader lack of uniformity in approaches to asylum planning in this period. Nevertheless, as Chris Philo has noted, most alienists tended to favour smaller institutions.⁶⁸ Faced with ever-rising numbers, mid-nineteenth-century asylum planners had increasingly to consider what effect increased scale would have upon patients' chances of recovery.

Smaller scale cottages offered one potential remedy to the apparent tension between pressure for institutional expansion, and a concern to provide an optimal environment for cure and convalescence. Cottages found particular acceptance among asylum planners in the 1850 and 1860s. J.T. Arlidge envisaged convalescent cottages as a 'valuable means of treatment' in their own right, and consequently suggested that such units held specific benefits for convalescents. In particular, Arlidge suggested that they could allow liberty to this discreet class of trusted patients, and furthermore cultivate a homely 'family' environment, which would help restore the patient to sustainable sanity. As such, Arlidge interpreted specific benefits of cottage treatment to the convalescent patient, by drawing a parallel between the home-like detached asylum block and patients' own homes.⁶⁹ Moving beyond the advantages cottage homes might present to stricter classification

⁶⁶ C. Lockhart Robertson, 'A Descriptive Note of the Sussex Lunatic Asylum, Haywards Heath (Opened 25 July 1859)', *Journal of Mental Science* 6 (April 1860), p. 267.

⁶⁷ C. Lockhart Robertson, 'The Care and Treatment of the Insane Poor', *Journal of Mental Science* 13 (October 1867), pp. 295-6.

⁶⁸ Philo, 'Enough to Drive One Mad', p. 274.

⁶⁹ Arlidge, *On the State of Lunacy*, pp. 142-5.

and greater differentiation, Arlidge thus suggested that the home environment itself exerted a positive influence on the process of convalescence. Ebenezer Toller (Medical Superintendent, Gloucester) shared the view that cottages could provide a more recognisably home-like environment, both to recent admissions, and those about to be discharged.⁷⁰ Such ideas revisited the idea of the half-way house discernible in Esquirol and the Tuke's separate buildings for convalescents, in ways that contrasted their homeliness against the institutional scale of central asylum buildings.

Historians of nineteenth-century asylum practice have suggested that convalescence assessed both moral and medical improvement. Consequently, they have suggested that convalescents in this period were defined by their ability and willingness to participate in socially-normative modes of activity and interaction, as well as by rationality and mood.⁷¹ The ordinariness of the environments made available to convalescents afforded particular opportunities to asylum planners who sought to test the normality of convalescents' conduct, beyond questions of rationality. It was the temperate outward appearance of the convalescent and quiet patients that John Bucknill highlighted in the 1850s, when he commented that they often walked along the shoreline 'side by side with other idle folk'.⁷² C. Lockhart Robertson, who in the 1860s modelled his own village-based cottage for

⁷⁰ E. Toller, 'Suggestions for a Cottage Asylum', *Journal of Mental Science* **10** (October 1864), pp. 343, 345.

⁷¹ Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian England* (Basingstoke, Hants; and New York: Palgrave Macmillan, 2004), p. 133; Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (Abingdon, Oxon: Routledge, 2006), pp.191-2; Sarah Hayley York, 'Suicide, Lunacy and the Asylum in Nineteenth-Century England' (PhD thesis, University of Birmingham, 2009), pp. 168-9.

⁷² John Charles Bucknill, 'Description of the New House at the Devon County Lunatic Asylum', *Journal of Mental Science* **4** (April 1858), p. 325.

convalescents in the 1860s, claimed in 1859 that 'the state of the affections' was 'of even more importance than the condition of the intellectual powers' to assessments of mental recovery.⁷³ Conformity with the behavioural expectations of those who managed such cottages, including assessments of empathy, therefore continued to provide a central test of their wellness. In a later paper, Robertson indicated that he had returned patients to the asylum in response to their complaints or restless behaviour in the convalescent home.⁷⁴ To some extent this suggests that patients themselves may have misbehaved as a result of a desire to remove themselves from unfamiliar surroundings; yet it also indicates that alienists themselves adjudged convalescence on the basis of tractability.⁷⁵

At the same time, however, John Bucknill's approach to mental convalescence suggests he considered it susceptible to physiological, as well as behavioural improvement. In 1858, Bucknill wrote effusively on the 'potent' tonic properties of sea air, stating that he knew 'of no remedy which we should recommend more generally and with greater confidence'.⁷⁶ Such ideas reflected a broader interest in the impact of fresh air on health pursued in early general convalescent homes in this period, and into the twentieth century, when it also formed a central part of sanatorium treatment for tuberculosis.⁷⁷ Bucknill, however, only adopted seaside treatment temporarily

⁷³ C. Lockhart Robertson, 'Notes on the Prognosis of Mental Disease', *Journal of Mental Science* 5 (January 1859), p. 271.

⁷⁴ C. Lockhart Robertson, 'On the Means of Extending the Public Asylum System: A Sequel', *Journal of Mental Science* 11 (April 1865), pp. 89-90.

⁷⁵ Digby, *Madness, Morality and Medicine*, p. 45.

⁷⁶ Bucknill, 'Description of the New House', p. 328.

⁷⁷ Lindsay Prior, 'The Local Space of Medical Discourse: Disease, Illness and Hospital Architecture', in Jens Lachmund and Gunnar Stollberg (eds), *The Social Construction of Illness* (Stuttgart: Franz Steiner Verlag, 1992), p. 70; Jeffrey S. Reznick, 'Rest, Recovery, and Rehabilitation: Healing and Identity in Great Britain in the First World War' (Emory University, unpublished PhD thesis, 1999), p. 70.

during the construction of chronic wards at Devon. Indeed, by 1879 Bucknill had evidently lost some faith in the benefits of sea air on convalescents, and claimed it had proven more useful for the 'physical health and... temporary enjoyment of chronic lunatics than... the mental improvement of those who are curable'.⁷⁸ More consistently, Bucknill retained a belief in the importance of homeliness and a clear separation between convalescents and other patients. As in the 1830s, Bucknill was partly influenced in his ideas by continental approaches to treatment, most notably the Belgian colony established at Gheel.⁷⁹ So too, his comparison in 1879 between the mental convalescent and those 'convalescing from pneumonia' strongly echoed W.A.F. Browne's earlier correlation between those recovering from fever and the similar need for isolation amongst the recently insane.⁸⁰

While historians have identified Bucknill as a relatively unorthodox and exceptional figure for his adoption of boarding-out, it is nevertheless possible to regard him as a conduit for continental ideas on convalescence.⁸¹ Several authors who later recommended the cottage system for convalescents cited Bucknill's influence. Few proved willing to recommend the adoption of the Gheel system in England; yet some like Robertson and George Mould adapted cottage systems for chronic and convalescent patients from the

⁷⁸ Bucknill and Tuke, *Manual of Psychological Medicine*, p. 693.

⁷⁹ William Parry-Jones, 'The Model of the Geel Lunatic Colony and Its Influence on the Nineteenth-Century Asylum System in Britain', in Andrew Scull (ed.), *Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era* (Philadelphia, PA: University of Philadelphia Press, 1981), p. 209.

⁸⁰ Bucknill and Tuke, *Manual of Psychological Medicine*, p. 684.

⁸¹ Parry-Jones, 'Model of the Geel Colony', pp. 209-13; Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c. 1870-1959* (Oxford: Oxford University Press, 1998), p. 118.

example Bucknill had provided.⁸² The practical model Bucknill established at Devon therefore introduced a principle of treatment derived from the Belgian system, and moreover demonstrated how it might be modified within English asylums. Others like John Sibbald, who was one of the few to condone boarding-out on the lines established at Gheel, similarly argued that cottages within asylums might prove more suitable for those 'in a probationary state... or liable to relapses'.⁸³ Bucknill contributed to the spread of such ideas on the potential uses of cottages for convalescents, both as the first editor of the *JMS* (1853–61), and independent author. Andrew Scull (*et al.*) has also noted that his textbook, first published in 1858, became the dominant reference for alienists throughout its four editions to 1879.⁸⁴ It is significant, therefore, that the final edition included several pages on the need for greater separation of convalescents from other patients, on the lines he introduced at Devon. Bucknill contributed further to the circulation of ideas on convalescence as host of the inaugural meeting of the MACA, and its first president from 1879.

Asylum planners in the 1850 and 1860s drew attention to the benefits asylum cottages might confer upon convalescents, yet their designs were rarely dedicated solely to this class of patient. Instead, the interchangeable use of cottages for different classes of patients, and planners' claims that they helped reduce overcrowding, suggests they served a more general function for the subdivision and extension of mid-century asylums. Practical

⁸² George W. Mould, 'Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association, Friday 30th July, 1880', *Journal of Mental Science* **26** (October 1880), p. 337; Robertson, 'A Sequel'.

⁸³ John Sibbald, 'The Cottage System and Gheel', *Journal of Mental Science* **7** (April 1861), p. 60.

⁸⁴ Scull (*et al.*), *Masters of Bedlam*, pp. 189, 199.

experience led others to introduce chronic patients into cottage accommodation that might otherwise have been dedicated to convalescents. Against expectations, Robertson concluded that the cottage he set aside for convalescents in the community neighbouring Sussex Asylum 'worked better for the chronic than with the convalescent patients'.⁸⁵ This willingness to substitute convalescent with chronic patients suggests that prognosis at this stage remained only a subsidiary consideration in the use of cottage systems. Several asylum planners looked beyond the specific needs of convalescents, and further advocated cottages for other well-behaved patients.⁸⁶ The Lunacy Commission in 1856 interpreted these cottages primarily as part of a broader plan for 'economical' institutional expansion. Only 'in addition to the saving of cost and time' such a plan promised did the Commissioners move on to consider its effectiveness 'as a means of treatment'.⁸⁷ While Chris Philo has questioned whether this amounted to advocacy of second-rate care for chronic patients, it also casts doubt over the Commissioners' commitment to the specific needs of convalescents.⁸⁸ This emphasis on rapid construction indicates the extent to which overcrowding may have influenced planners to commence with cottage plans; indeed, Ebenezer Toller admitted in 1864 that he had first considered the cottage system as a remedy to the overcrowding he found at Gloucester Asylum.⁸⁹

⁸⁵ Robertson, 'A Sequel', p. 90.

⁸⁶ Ibid., p. 343; Mould, 'Presidential Address', p. 336; Henry Maudsley, 'Middle-Class Hospitals for the Insane', *Journal of Mental Science* 8 (October 1862), p. 362.

⁸⁷ Lunacy Commission, *Annual Report*, 1856, p. 28.

⁸⁸ Philo, 'Enough to Drive One Mad', pp. 278-9.

⁸⁹ Toller, 'Suggestions for a Cottage Asylum', p. 342.

A need for additional beds partially explains the popularity of detached cottages from the 1850s, yet the decision to opt for this mode of expansion apparently rested on more than simply economy. Indeed, some authors claimed cottages were more expensive than alternative arrangements. George Mould introduced three supplementary 'villas or cottages' at Cheadle Asylum in 1864 for chronic and convalescent patients. Recounting their advantages in 1880, Mould argued that, while it would have proven cheaper to congregate chronic patients in larger wards, cottages proved more effective because they encouraged 'quiescence' and a sense of 'home-like freedom' amongst their residents.⁹⁰ An editorial in the *Lancet* of 1865 similarly identified vertical or horizontal construction from a central asylum block as the cheapest means of institutional enlargement. Even so, the author recommended other options, such as separate blocks 'adapted for the convalescing and quieter', where the main asylum accommodated more than 800 patients.⁹¹ Other considerations besides cost therefore influenced asylum planners in the choices they made between alternative design schemes. Authors such as Arlidge and Mould shared the *Lancet's* preference for smaller asylums, which they prioritised above small differences in cost. As David Cochrane and Mathew Thomson have argued for early twentieth-century villa systems, it seems likely that the mid-nineteenth-century cottage plan resulted from concerns to reduce overcrowding, maintain classification, and enhance the public image of the asylum.⁹²

⁹⁰ Mould, 'Presidential Address', pp. 336-7.

⁹¹ 'The Overgrowth of Our Public Lunatic Asylums', *Lancet* **84**, (2 July 1864), p. 21; 'The Overgrowth of Our Public Lunatic Asylums', *Journal of Mental Science* **10** (January 1865), pp. 620-1.

⁹² Thomson, *Problem of Mental Deficiency*, p. 120.

Asylum planners in the 1850s and 1860s repeatedly contrasted the small scale of the cottage, against the overbearingly large central asylum block. A previous generation of planners had principally concentrated on the degree of classification and separation necessary to safeguard sustained improvement amongst convalescents. From the 1850s, however, authors started to pay additional attention to the potential value smaller-scale home-like buildings might also have for these patients. The Lunacy Commission in 1856 contrasted the lower prospects convalescents faced when discharged from 'large' centralised asylum blocks, as compared with the benefits of 'intermediate' cottages on a smaller scale.⁹³ So too, J.T. Arlidge in 1859 argued for small convalescent cottages, to provide a more recognisably domestic environment than the typical asylum block that he compared with 'an extensive factory, workhouse, or barrack'.⁹⁴ Such comparisons, Felix Driver has suggested, became widespread in the 1860s, as part of a general reaction against 'the apparent failure of the large "barrack" designs' found in institutions such as workhouses, asylums and prisons.⁹⁵ This sense of failure is evident in the writing of those such as J. Mundy and Toller, who showed particular concern for the overbearing scale of asylums and the effect they had on public attitudes. In 1861, Mundy advocated the 'family-like regime' of cottage plan asylums in contrast to 'so-called model asylums', which he likened to 'citadel-like barracks, or prison-houses'.⁹⁶ Toller warned that 'nothing but the cottage system' would 'break down the prejudice against

⁹³ Lunacy Commission, *Annual Report*, 1856, p. 28.

⁹⁴ Arlidge, *State of Lunacy*, p. 143.

⁹⁵ Felix Driver, *Power and Pauperism: The Workhouse System, 1834-1884* (Cambridge: Cambridge University Press, 1993), pp. 66-7.

⁹⁶ J. Mundy, 'Five Cardinal Questions on Administrative Psychiatry', *Journal of Mental Science* 7 (October 1861), p. 368.

asylums that still exists in the minds of the public'.⁹⁷ As such, both authors considered smaller cottage units as a remedy to the stigmatised image of the asylum, as well as their function.

A loss of faith in the asylum, however, also seems to have encouraged others over the course of the late nineteenth century to consider whether convalescents could ever be satisfactorily treated within these institutions. Theories of degeneration, such as those expounded in Henry Maudsley's *Responsibility in Mental Disease* (3rd edition, 1876), suggested that most cases of insanity resulted from hereditary organic dysfunction. Maudsley held out little hope for these patients, and even amongst that minority of cases attributable to 'functional' (non-organic) disorder, questioned whether institutional treatment would help.⁹⁸ In his 1871 presidential speech to the Medico-Psychological Association (MPA), Maudsley speculated that many long-stay cases were 'asylum-made lunatics'.⁹⁹ Although controversial, others recognised failure in the curative ambitions of the asylum. A year after Maudsley's speech, in 1872, James Coxe as President of the MPA told this association that the optimism behind the post-1845 wave of asylum construction had 'not been realised'. Again challenging asylums' therapeutic utility, Coxe questioned how far recoveries resulted simply from spontaneous remission.¹⁰⁰ Such comments cast doubts over the future prospects of asylums as curative institutions, and as Roy

⁹⁷ Toller, 'Cottage Asylum', p. 344.

⁹⁸ Henry Maudsley, *Responsibility in Mental Disease* (London: C. Kegan Paul, 1876, 3rd edition), p. 283; Vieda Skultans, *English Madness: Idea on Insanity, 1580-1890* (London: Routledge & Kegan Paul, 1979), pp. 182-3; Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), pp. 148-51.

⁹⁹ Henry Maudsley, 'Insanity and Its Treatment: Presidential Address', *Journal of Mental Science* **17** (October 1871), pp. 311-34.

¹⁰⁰ James Coxe, 'On the Causes of Insanity, and the Means of Checking its Growth; being the Presidential Address', *Journal of Mental Science* **18** (October 1872), pp. 315-6.

Porter has suggested, indicate a sense of failure at the increasingly overcrowded state of British asylums.¹⁰¹ As a result, a few alienists began to consider alternatives to asylum treatment. MPA President for 1874, Thomas Lawes Rogers echoed Coxe in his argument that unassisted recoveries provided the 'strongest argument' for a shift in professional attention from asylum treatment, to preventive medicine.¹⁰² The source of these criticisms in the speeches of three MPA presidents indicates that even leading alienists proved willing by the 1870s to question the usefulness of asylums to psychiatric recovery.

It is significant that the founder of the largest voluntary organisation to provide convalescence, Henry Hawkins, worked at an asylum that already featured its own onsite convalescent unit. Colney Hatch Asylum, which employed Hawkins as a chaplain, had in 1865 converted a former isolation block for convalescents (Figure 1).¹⁰³ Even though it is highly probable that Hawkins would have known about this block, he chose to argue that the practice of convalescence belonged at least partly outside the asylum and in the 'healthier atmosphere of ordinary life'. Hawkins's proposal in 1871 that voluntary convalescent homes were needed to perfect recoveries, therefore served as an implicit rejection of the idea that asylums were themselves sufficient to promote mental health.¹⁰⁴

¹⁰¹ Porter, *Madness*, p. 147.

¹⁰² Thomas Lawes Rogers, 'The President's Address', *Journal of Mental Science* **20** (October 1874), p. 342

¹⁰³ Richard Hunter and Ida MacAlpine, *Psychiatry for the Poor: A Medical and Social History* (London: Dawson's, 1974), pp. 61-2.

¹⁰⁴ Henry Hawkins, 'A Plea for Convalescent Homes in Connection with Asylums for the Insane Poor', *Journal of Mental Science* **17** (April 1871), p. 107.



Figure 1: Detail of Copy Plan of Colney Hatch Asylum, showing Convalescent Home, c.1900. This was originally intended as an isolation hospital, but by 1865 had been given over to convalescents. The relocated isolation hospital is shown at the top of the plan; the rear of the main asylum complex is visible at the bottom right.

Source: LMA, Friern Hospital, Administration: Plans concerning Hospital Site and Buildings, H12/CH/A/32/004.

In a climate of therapeutic nihilism, it was perhaps unsurprising that some alienists began to consider alternatives to asylum convalescence. Alienists' involvement in the MACA reflected an increasing pessimism in the double-danger that institutionalisation, as well as the community outside,

might pose to patients' recoveries. Among those alienists who became involved in the early work of the MACA, Henry Rayner (Physician, St Thomas's), in 1891 suggested to its members that the charity assisted those who in their convalescence were 'strange to the world from which he has been isolated for months or years'. Equally, however, Rayner observed that the charity's cottage homes also helped avoid patients from having to return to undesirable homes.¹⁰⁵ Two months before the MACA's inception, another future member, George Savage, warned fellow alienists that in his experience at Bethlem, patients became habituated to the 'insane surroundings of asylums... and by residence in an asylum be[come] unfit for the outer world'.¹⁰⁶ Alienists therefore in some cases shared Hawkins's concern at the effects of institutionalisation on patients' ability to cope with the transition to wider society.

Others, however, rejected the idea that asylums might retard or even contribute to mental illness and instead presented them as a preferable option compared with the perils of domestic convalescence. Whilst Colney Hatch Asylum's chaplain sought to remove convalescents into more normal social contexts, one of this institution's superintendents contested that newly-recovered patients actually needed the protection asylums afforded from the outside world. Thus, Edgar Shepherd (Superintendent, 1862–81) rejected Maudsley's claim that asylums perpetuated lunacy and countered that this

¹⁰⁵ Henry Rayner, 'After-Care of Male Patients Discharged from Asylums', *Journal of Mental Science* **38** (October 1891), pp. 536-7. Rayner had previously worked as Assistant Medical Officer, Bethlem (1870-2), and then as Medical Superintendent, Hanwell Asylum (1872-88). Between 1877–89 he worked as General Secretary, RMPA, and from 1891 as the MACA's treasurer.

¹⁰⁶ George Savage, 'Two Cases of Recovery from Insanity, after Many Years in An Asylum', *Journal of Mental Science* **25** (April 1879), p. 57. Savage succeeded Rayner as Assistant Medical Officer at Bethlem in 1872, before he became its Physician Superintendent in 1879.

view paid insufficient credit to their role in shielding patients from the ‘briars and thorns’ of life in the community.¹⁰⁷ While Andrew Scull has claimed Maudsley’s 1871 paper had little impact upon wider psychiatric thought, it nevertheless later incensed or inspired others into a response.¹⁰⁸ In 1889, A.R. Urquhart (Superintendent, Perth Asylum) felt it necessary to counter the periodic and ‘strongly expressed’ idea of ‘asylum-made lunatics’. Like Shepherd, Urquhart defended the asylum as the appropriate place for recovery, and suggested that with due attention to design asylums could lessen the effects on sensitive patients once ‘plunge[d]... into a mad world’.¹⁰⁹ Of more significance to general asylum planning, Montagu Lomax returned to Maudsley’s idea of ‘asylum-made lunatics’, as part of an appeal for asylum reform in the 1920s.¹¹⁰ The *JMS* and other publications, as much as the MACA (see Chapter Three), therefore provided an important medium for alienists and others interested in convalescence to contest, and construct, the nature of any discontinuities between institutional treatment and social life.

Throughout the nineteenth century and into the 1900–10s, asylum planning continued to be marked by heterodoxy. Recommendations for the ideal position for convalescents ranged from homes entirely removed from the asylum estate, to a renewed emphasis on centralised wards, with little agreement over where these patients belonged. Clare Hickman and Chris

¹⁰⁷ Edgar Shepherd, ‘On Some of the Modern Teachings of Insanity’, *Journal of Mental Science* 17 (January 1872), pp. 512-4.

¹⁰⁸ Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (London; and New Haven, CT: Yale University Press, 1993), pp. 332-3.

¹⁰⁹ [A.R. Urquhart, *Perth Asylum Annual Report*, 1889, cited in:] ‘English Retrospect’, *Journal of Mental Science* 38 (January 1892), p. 136.

¹¹⁰ Montagu Lomax, *The Experiences of an Asylum Doctor* (London: George Allen and Unwin, 1921), p. 39.

Philo have argued that asylums remained committed to an ideal of homeliness throughout the nineteenth century, which alienists claimed to achieve through open-door policies, and detached buildings.¹¹¹ Indeed, Jeremy Taylor has indicated that some asylums continued to add convalescent cottages into the 1880s, as part of a broader agenda of functional subdivision.¹¹² The *JMS*, however, suggests that many asylum planners came to favour greater centralisation, which placed convalescents in closer proximity to other wards. In the 1880s, the superintendents Richard Greene (Berry Wood, Northampton) and C.S.W. Cobbald (Earlswood, Redhill) each proposed model asylum plans that featured first-floor convalescent wards above ground-floor infirmaries. Outwardly, the corridors that linked these designs also identified convalescence as just one of several species of insanity in a much larger institution.¹¹³ It appears centralisation reflected a concern to more easily and cheaply manage the ever larger numbers admitted to asylums in this period; a suspicion reflected in the claims made by Greene and others. While Greene focused particularly on the low cost and accessibility of connected block plans, others like the architect George Bibby (1889) advised that successful plans would locate all buildings 'within a reasonable distance of the administrative department'.¹¹⁴

¹¹¹ Hickman, 'Vis Medicatrix Naturae', p. 99; Chris Philo, *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter, Ceredigion; and New York: Edwin Mellen Press, 2004), pp. 610-11.

¹¹² Taylor, *Hospital and Asylum Architecture in England*, p. 149.

¹¹³ Richard Greene, 'A Public Asylum, Designed for 414 Beds, Capable of Extension to 600', *Journal of Mental Science* **27** (July 1880), p. 237; C.S.W. Cobbald, 'Design for a Public Asylum for 310 Patients, allowing for extension of Accommodation up to 450 Beds', *Journal of Mental Science* **32** (January 1886), pp. 473-4.

¹¹⁴ Greene, 'Public Asylum for 414 Beds', p. 244; George H. Bibby, *Asylum Construction and Arrangement* (London: Drake, Driver and Leaver, 1889), p. 42.

Despite a continued emphasis on economy in asylum design, and the lack of a uniform approach to planning for convalescence, alienists in this period did evaluate patients' needs according to prognosis. Psychiatric textbooks published from the 1880s to the 1910s suggest that some alienists at least regarded convalescence as a distinctive and significant period in psychiatric treatment. Tonics, nourishment and graduated exercise indicated specifically in these textbooks for recovering patients helped identify recovery itself as a specific phase of asylum care.¹¹⁵ Alienists, however, also recognised dissimilarities in recovery between different diagnoses, in ways that to a limited extent complicated the definitional integrity of convalescence as a distinct category. Textbooks repeatedly implied that recovery in melancholia would take longer than in mania. So too, Thomas Clouston (1883) perceived that swearing marked the onset of recovery in melancholics, in contradistinction to the rationality and tractable willingness to work he saw as key signs of improvement amongst manic patients.¹¹⁶ It is possible, therefore, to see 'convalescence' as a catch-all term, which masked differences in the process and progression of recovery between different diagnoses. Even so, alienists such as John Bucknill and Daniel Hack Tuke (1879), and George Savage and Edwin Goodall (1907) also proposed more general therapeutic considerations of benefit to all convalescents.¹¹⁷ It is perhaps significant that all these authors also took an

¹¹⁵ Thomas Clouston, *Clinical Lectures on Mental Diseases* (London: J. & A. Churchill, 1883), pp. 131-4, 209-10; George H Savage and Edwin Goodall, *Insanity and Allied Neuroses: A Practical and Clinical Manual* (London and Paris: Cassell, 1907, 4th edition), pp. 116, 165; R.H. Cole, *Mental Diseases: A Text-Book of Psychiatry for Medical Students and Practitioners* (London: University of London Press, 1913, 1st edition), pp. 114, 123.

¹¹⁶ T.S. Clouston, *Clinical Lectures on Mental Diseases* (London: J. & A. Churchill, 1883), pp. 131-2.

¹¹⁷ Bucknill and Tuke, *Manual of Psychological Medicine*, pp. 683-4; Savage and Goodall, *Insanity and Allied Neuroses*, p. 126.

active role in the early years of the MACA, while both Bucknill and Savage respectively had experience with using separate asylum convalescent homes at Exeter and Bethlem.¹¹⁸ Consequently, these alienists had actively participated in the primary separation of patients according to their prognosis, which their subsequent textbooks replicated in the identification of commonalities amongst convalescents regardless of diagnosis. In turn, such textbooks further helped define convalescence as a particular target for psychiatric practice.

Asylum planners had fewer options over where to locate pauper convalescents than were available to private and registered institutions. These options included the provision of separate seaside or country convalescent homes, which asylums for paying patients such as Bethlem (1870), the York Retreat (1887) and Holloway Sanatorium (by 1891) all opened in the late nineteenth century.¹¹⁹ Sue Farrant has suggested that seaside resorts reached the 'peak of their popularity' in the 1880s, which she has partly perceived in the marked increase in the number of general convalescent homes along the south coast around this period.¹²⁰ The decision of asylums to relocate mental convalescents to the sea and country conform to these broader trends in convalescent care. Because private and registered asylums could admit paying patients as voluntary boarders, their

¹¹⁸ Savage worked as Assistant Medical Officer (1872-9) then Physician Superintendent (1879-88) at Bethlem, which had opened a separate convalescent branch at Witley in 1871. Savage's articles in the *JMS* indicate that Savage made use of the home at Witley. See George H. Savage, 'Two Cases of Recovery from Insanity, after Many Years in an Asylum', *Journal of Mental Science* **25** (April 1879), p. 58; George H. Savage, 'Presidential Address', *Journal of Mental Science* **32** (October 1886), p. 330.

¹¹⁹ 'Asylum Reports', *Journal of Mental Science* **33** (January 1888), p. 617; 'Asylum Reports', *Journal of Mental Science* **37** (October 1891), p. 603; Digby, *Madness, Morality and Medicine*, p. 69.

¹²⁰ Sue Farrant, 'London by the Sea: Resort Development on the South Coast of England, 1880-1939', *Journal of Contemporary History* **22** (January 1987), pp. 137, 140-5.

homes appealed to those who might otherwise have taken advantage of the array of spas, holiday destinations and nursing homes available to wealthier patients in the nineteenth century to manage their 'nerves'. Phyllis Hembry and Roy Porter for example have suggested that spas retained much of the popularity among such patients as a place of recuperation before 1914.¹²¹ Those unable to afford to pay for care, however, could only rely on charities, or enter asylums as certified patients, whilst these public asylums were themselves circumscribed in the forms of convalescence they could provide. Even in the late 1930s, the Board of Control felt unable to approve plans for convalescent homes, where their distance from the central asylum made them difficult to interpret as 'annexes' under the Lunacy Acts.¹²² While the MACA's voluntary cottage homes offered rate-assisted patients localised access to seaside and country convalescence from the 1880s, asylum planners in the public asylum system could apparently only contemplate homes in the immediate vicinity of the parent institution.

Late nineteenth-century planners further began to explore ways to protect patients by prognosis within the asylum. In contrast to earlier proposals for convalescent cottages, which tended to view the convalescent in isolation, alienists from the 1870s increasingly began to consider ways to intervene at an earlier stage, and prevent patients from ever reaching central asylum buildings. In 1879, J. Wilkie Burman (Superintendent, Wiltshire) suggested that recent cases should be housed in a separate detached hospital, where they could be 'discharged without ever having been

¹²¹ Porter, *Madness*, p. 87; Phyllis Hembry, *British Spas from 1915 to the Present: A Social History* (London: Athlone, 1997), p. 243.

¹²² The National Archives, Lunacy Commission and Board of Control, Minutes, MH 50/53, 25 January and 8 February 1938.

indiscriminately sequestered in the asylum'. This idea of a closed loop, cut off from what Burman termed the 'safety house' of the central asylum, would become pivotal to the interwar development of associated admission hospitals and convalescent villas.¹²³ The Lunacy Commission's revised *Suggestions for the Construction of Lunatic Asylums* (1871) recommended the placement of reception wards within central asylum buildings.¹²⁴ Nevertheless, from the 1870s some asylums began to experiment with a clearer division between the curable and incurable, on the lines Burman had suggested. In Scottish asylums in particular, between the 1880s and mid-1890s, it became standard to provide separate buildings for a small number of physically sick and later acute cases. Some, like Inverness, also made provision for associated convalescent wards by the 1890s, and thereby adopted the sort of association between admission and recovery that Burman envisaged.¹²⁵ In a further sign that planning on the basis of recoverability spanned the borders John Wallis published plans in 1894 for a detached hospital that would admit the curable and potential curable, which was opened at Whittingham (Lancashire) in 1899–1900.¹²⁶

¹²³ J. Wilkie Burman, 'On the Separate Care and Medical Treatment of the Acute and Curable Cases in Asylums', *Journal of Mental Science* **24** (October 1879), pp. 323-4.

¹²⁴ Charles Palmer Phillips, 'Commissioners in Lunacy Suggestions and Instructions for the Construction and Arrangement of Lunatic Asylums', *Journal of Mental Science* **19** (January 1871), p. 627.

¹²⁵ J. Macpherson, 'The Hospital Treatment of the Insane in Asylums', *Journal of Mental Science* **42** (October 1896), 778-87.

¹²⁶ John A. Wallis, 'On the Separate Treatment of Recent and Curable Cases of Insanity in Special Detached Hospitals', *Journal of Mental Science* **40** (July 1894), p. 335.

4. An Emerging Consensus? The Admission Hospital and Convalescent Villa, 1898–1939

Nineteenth-century asylum planners introduced several key precepts that were pivotal to the development of separate facilities for so-called convalescent patients in the interwar period. In particular, the idea that convalescents might benefit from more home-like and smaller cottage units provided a model for the twentieth-century convalescent villa. In their small scale and separation from centralised asylum blocks at least, a lineage is apparent between experiments such as the Appendage in the 1810s, W.A.F. Browne's asylum blocks for convalescents of the 1830s, the voluntary seaside homes of the 1850–90s, and the hybrid system of mental hospital villas and cottage homes of the 1920–30s. Most fundamentally, proposals for detached hospitals evolved between the 1870s and the 1890s shifted the basis of classification from behavioural to prognostic assessments. For much of the century, the distinction between accommodation for chronic and convalescent cases remained ambiguous. Indeed, asylum planners often designated shared wards for convalescent, tranquil and chronic patients, on the basis of behaviour. In contrast, some institutions such as Whittingham in Lancashire at the end of the century had dedicated a block specifically for reception and convalescent hospitals on the basis of curability, which anticipated trends in interwar mental hospital planning. Nineteenth-century asylum planners, however, reached only limited consensus over asylum design. While Jeremy Taylor has argued sunshine and south-facing views became 'central to any design solution' over the nineteenth century, the

place of convalescents within these institutions remained broadly unsettled.¹²⁷

The emergence of the convalescent villa in England is initially attributable to two factors that had exerted a significant influence on nineteenth-century planning for convalescents: continental ideas, and domestic overcrowding. Over 1900 and 1901, the Lancashire Asylums Board (LAB) and London County Council (LCC) each commissioned surveys on foreign approaches to asylum design ahead of plans for new asylums. By 1901, every fully-operational asylum run by these authorities accommodated more than 2,000 patients – double the national average – while between them these authorities ran the two largest institutions in the country.¹²⁸ In just fourteen years between 1893 and 1907, the LCC had opened six new asylums, as part of what David Cochrane has termed a ‘metropolitan... building spree’.¹²⁹ The simultaneous publication of independent reports into continental approaches to asylum planning reflected a need at both authorities to accommodate and ideally cure ever-larger numbers of patients. In 1896, the LCC set up an Accommodation Sub-Committee to consider ‘better and less expensive’ asylum accommodation, with due consideration to ‘systems adopted in the principle European and American cities’.¹³⁰ This represented a wholesale reassessment of existing principles of asylum

¹²⁷ Taylor, *Hospital and Asylum Architecture*, p. 149.

¹²⁸ On 1 January 1901, London’s six main asylums accommodated an average of 2,374 patients whilst Lancashire maintained a mean of 2,246 patients. Prestwich Asylum (2,714) in Lancashire was then the largest in the country, closely followed by London’s Colney Hatch Asylum (2,538).

¹²⁹ David Cochrane, “‘Humane, Economical, and Medically Wise’: The LCC as Administrators of Victorian Lunacy Policy”, in W.F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III: The Asylum and its Psychiatry* (London and New York: Routledge, 1988), p. 266.

¹³⁰ London Metropolitan Archives [LMA], London County Council [LCC], Asylums Committee, Special Housing and Treatment of Lunatics Sub-Committee, LCC/MIN/710-14, Minutes, 17 November 1896, pp. 1-2.

treatment, albeit one that focused in the short-term on plans for an additional institution (Ewell, 1903), rather than thoroughgoing reform of older asylums.¹³¹ With a similar sense that other countries might hold potential solutions to domestic problems, the LAB's report, published in 1900, contrasted its 'favourable' impressions of German asylums with its own 'full and congested' institutions.¹³² Winwick Asylum opened as a result of this report in 1902.¹³³ In each case, therefore, the catalyst behind these authorities' interest in continental planning techniques originated in a desire to remediate oversized institutions.

The LAB, which reported first in 1900, favoured the construction of an institution entirely dedicated to chronic patients based on the Germanic system. Such ideas were not wholly new: J.T. Arlidge had observed in 1859 that while British and French asylums tended to classify patients within single institutions, German asylums specialised between chronic and acute. Indeed, Arlidge had even gone so far as to support the introduction of dedicated chronic asylums in Britain.¹³⁴ The LAB went beyond late nineteenth-century approaches of classification that placed acute hospitals adjacent within a single asylum estate and at Winwick (1902) finally implemented the sort of chronic asylum Arlidge had envisaged. Yet the idea proved unpopular in practice, and it would be the LCC's suggestion for more

¹³¹ The same budget set aside for the Clifford Smith's (Asylums Engineer, LCC) tour of continental and Scottish asylums was also put towards costs for blueprints for a new asylum based on his findings, which eventually opened as Ewell Asylum in 1903. LMA, LCC, Asylums Committee, Special Housing and Treatment of Lunatics Sub Committee Minutes, 16 July 1901.

¹³² Lancashire Asylums Board [LAB], *Asylums on the Continent* (Salford: W.F. Jackson and Sons, 1900), p. 69.

¹³³ 'Asylums on the Continent: Report of a Deputation of the Lancashire Asylums Board', *Journal of Mental Science* **47** (July 1901), p. 564.

¹³⁴ Arlidge, *On the State of Lunacy*, p. 141.

clearly defined subdivisions between the curable and incurable within a single asylum site that proved more popular in the interwar period. Winwick's own superintendent Dr Simpson, quoted by the equally critical Chairman of the Chorlton and Manchester Asylum Committee, complained of the 'depressing effect' chronic asylums had upon both patients and staff upon 'seeing that they have no convalescent cases'.¹³⁵ Such responses suggest professional motives may have lain behind the reluctance of other authorities to build their own chronic asylums, as Mathew Thomson has found in different contexts in his study of the colony solution for mental defectives.¹³⁶ This desire to preside – and be seen to preside – over more obviously curable convalescent inmates would prove central to the emergence of convalescent villas in the interwar mental hospital.

The origins of the interwar convalescent villa can be detected in the LCC's report on continental asylums, published in 1901, a year after the LAB's. Clifford Smith (Asylums Engineer, LCC) drew upon the LAB's reports, the observations of T.E.K. Stansfield who had earlier visited asylums in Germany, and his own correspondence and visits to British and continental asylums during the spring of 1901.¹³⁷ On the basis of this information, Smith recommended the division of the next LCC asylum (Ewell: 1903) into three separate sections. These comprised a 'hospital' section for the recent, acute and convalescent; a simpler hospital for refractory and infirm chronic cases;

¹³⁵ John Milsom Rhodes, 'The Provision of Suitable Accommodation for the Various Forms of Insanity', *Journal of Mental Science* **52** (October 1905), p. 684.

¹³⁶ Mathew Thomson, "'Though Ever the Subject of Psychological Medicine': Psychiatrists and the Colony Solution for Mental Defectives', in Hugh Freeman and German E. Berrios (eds), *150 Years of British Psychiatry Volume II: The Aftermath* (London and Atlantic Highlands, NJ: 1996), pp. 132, 136-40.

¹³⁷ LMA, LCC, Asylums Committee, Special Housing and Treatment of Lunatics Sub Committee Minutes, 17 November 1896, 14 May 1901.

and villas or detached houses for quiet and harmless patients.¹³⁸ While Smith followed the LAB in being complimentary about the rigorousness of German classification, he proved unwilling to commend different functions for different asylums. Instead, it is possible to see his approach as a synthesis of the continental, Scottish, and English approaches to asylum design. Among the LCC's asylums, Colney Hatch had already adapted an infectious diseases hospital for convalescents in 1865, while other asylums had also since developed detached hospitals, cottages and villas. It was on this evidence that Smith claimed his proposal represented the 'furtherance of [a]... system which has been employed on a small scale for years'. Even so, the system Smith eventually chose made a clearer division between curable and incurable than was then practised in any London asylum. While the LCC had its own examples of detached units at this date, the plan they would adopt from the 1900s would share more in common with 'bijou asylum' for recent cases visited at Whittingham and prognostic classification found at German asylums such as Alt Scherbitz.¹³⁹

These asylums in other countries provided a practical template for the sort of primary separation of recoverable patients that others on the LCC's Asylums Committee had already previously considered. Throughout the 1890s the LCC petitioned Parliament for legislation that would enable it to establish 'reception houses'. These were intended to temporarily accommodate those recently certified patients held in workhouses or the

¹³⁸ London County Council, *Notes on a Visit to Continental and British Asylums* (London: James Truscott and Son, 1901), pp. 101-2.

¹³⁹ *Ibid.*, pp. 37-43, p. 92.

wider community in the period prior to their admission into an asylum.¹⁴⁰

Smith's proposal for a separate section for recent admissions therefore followed the Council's earlier unsuccessful attempts to provide a halfway house into the asylum. One LCC Asylums Committee proposal for such a system in 1897 justified their use as an alternative to immediate workhouse or asylum admission, which the report's author claimed respectively stigmatised the patient with 'pauperism' and 'lunacy'.¹⁴¹ It is likely that the LCC Asylums Committee began to focus on ways to reform asylum admissions partly as a result of the failure of such proposals. Indeed, Smith's proposals followed a similar line to an idea fellow LCC Asylums Committee member George Smith had put forward two years earlier in 1899, when he proposed future LCC asylums should feature a separate 'hospital section'. Recent admissions would be treated and observed here, Cooper suggested, and with other 'recoverable' patients thereby 'jealously separated' from a larger section for chronic cases.¹⁴² To some extent, therefore, the LCC had begun to establish the principle of a decisive separation of recoverable patients from others in the period before Smith's report, even though it also seems likely asylums in other countries influenced the shape such a division would eventually take.

Despite the LAB and LCC's systematic approach to research for the best solution to asylum planning between 1900 and 1901, the principle of

¹⁴⁰ Wellcome Library, MS 7913/19, Alexander Walk, 'Mental Health Legislation' (unpublished MS, 1968) pp. 12-13.

¹⁴¹ LMA, LCC, Asylums Committee, Accommodation Sub-Committee, Special Housing and Treatment of Lunatics Sub-Committee, *Minutes*, R.W. Partridge (LCC Asylums Committee), *Report of the Clerk as to a Scheme for Providing Receiving Houses*, 18 November 1897, p. 6.

¹⁴² LMA, LCC, Asylums Committee, Accommodation Sub-Committee, Special Housing and Treatment of Lunatics Sub-Committee, *Minutes*, 5 July 1899, pp. 91-2.

complete separation of recoverable patients developed only gradually. Indeed, at this stage, the appropriate type of housing for convalescents appeared almost as an afterthought in Smith's report, which concluded that for these patients, 'houses of the villa type would probably suffice'.¹⁴³ Smith's report clearly established the principle that recent and recoverable patients should occupy a separate part of the site; how these patients might be arranged, and the form of their accommodation, however, remained broadly unsettled. The LCC's Bexley Asylum (1898) provided a template for satellite villas around a central asylum building, yet its initial use for a variety of patients more closely resembled a broader nineteenth-century cottage system than a system designed for the recoverable. Its architect, G.T. Hine, planned three villas for 35 patients each, and what *London* described in the year it opened as a 'special hospital villa' for 50 women, which to some extent suggested a focus on the curable. Nevertheless, Hubert Bond, who worked at Bexley around the turn of the century, would recount in 1939 that 'neither why they were placed in the positions each occupied nor what functions each was intended to serve did any one know [*sic*]'.¹⁴⁴

Correspondence on the design between the Lunacy Commission and Hine supports Bond's view. In both 1895 and 1897, the Commissioners pressured Hine to move the villas closer to the main building, yet nowhere did they mention why.¹⁴⁵ Whilst recognised contemporarily as well as more recently by historians as the first example of the villa plan in England, it appears

¹⁴³ LCC, *Continental and British Asylums*, p. 101.

¹⁴⁴ Bond, 'T.E.K. Stansfield', pp. 1136-7.

¹⁴⁵ TNA, Ministry of Health, Board of Control, Bexley Health Asylum, correspondence and plans, 1896-1902, MH 83/182, memoranda from the Lunacy Commission to G.T. Hine, 14 May 1895 and 12 November 1897.

rather that the function of this villa plan changed over time, in ways unintended upon its inception.¹⁴⁶

With hindsight, Bond in 1939 considered that Bexley's superintendent had been 'puzzlingly content' to house the chronic and convalescent together.¹⁴⁷ Bond's comments exemplify the growth in expectations during the interwar period that recoverable patients should be set apart from all other cases. At the turn of the century, however, this principle was still open to debate, as evidenced in Clifford Smith's description in 1901 of the system then in use at Bexley as a 'trial'.¹⁴⁸ Only Bexley at this stage featured such purpose-built villas, even though they were also planned for Horton Asylum (1902), then under construction. Moreover, Hine followed other nineteenth-century asylum planners in his relative lack of specificity compared with subsequent twentieth-century planners on the benefits cottages might offer a variety of tranquil patients. In a paper published in 1901, Hine would suggest that detached villas might be used for 'convalescents or quiet chronic patients'.¹⁴⁹ As had previous asylum planners in the 1850s, therefore, Hine left ambiguous the extent of any difference in the design between detached units respectively built for chronic and convalescent patients. It appears that some at least regarded villas for chronic and convalescent patients as essentially the same. David Cochrane has indicated that the plans for Ewell favoured epileptics with a higher standard of accommodation than the 'common lunatic', yet it appears that convalescents had historically benefited

¹⁴⁶ 'The Construction of Asylums', *Journal of Mental Science* **47** (April 1901), p. 422; Taylor, *Hospital and Asylum Architecture*, p. 152.

¹⁴⁷ Bond, 'T.E.K. Stansfield', pp. 1135-6.

¹⁴⁸ LCC, *Continental and British Asylums*, p. 102.

¹⁴⁹ George T. Hine, 'Asylums and Asylum Planning', *Journal of the Royal Institute of British Architects* **8** (9 February 1901), pp. 177.

from comparable privileges.¹⁵⁰ When the Chairman of the LCC's Accommodation Sub-Committee suggested that detached villas would provide them with 'special treatment' and the 'ordinary freedom of the home', therefore, it tapped into a similar rhetoric of homeliness and comfort widely applied to convalescent villas.

There is some evidence, however, that planners had begun to associate the use of villas with a distinct subset of recoverable patients. In the discussion that followed Hine's paper, Lunacy Commissioner Edward Marriott Cooke would suggest that villas should ordinarily be confined to the 'segregation and special treatment of all recent cases which presented any prospect of cure'.¹⁵¹ While Bond later derided the 'tentative and rather dubious' villa system established at Bexley, it is equally notable that the asylum's superintendent, T.E.K. Stansfield took steps fairly quickly to appropriate one of these villas for convalescents.¹⁵² Stansfield therefore introduced Cooke's principal that both convalescent and hospital cases should be placed outside the main asylum building, even if this arrangement had not does seem to have formed part of Hine's original design vision. Scottish asylums which had begun to provide hospitals with convalescent wards by the 1890s in some cases adapted a system directly comparable with the LCC's. In 1906, Ayr Asylum opened a detached reception house with convalescent villas for 'convalescent and better-behaved patients'. Although this reference to patients' behaviour suggests such units were still not made available on prognosis alone, it nevertheless indicates a parallel

¹⁵⁰ Cochrane, 'Humane, Economical and Medically Wise', p. 258.

¹⁵¹ Hine, 'Asylums and Asylum Planning', p. 181.

¹⁵² Bond, 'T.E.K. Stansfield', p. 1136.

movement in Scotland in this period for a clearer separation of the recoverable from what Ayr's superintendent termed the 'asylum proper'.¹⁵³ H. Hayes Newington's design for East Sussex Asylum (1900) similarly incorporated a separate section that he claimed represented 'the first in the kingdom... devoted solely to recoverable patients'.¹⁵⁴ This claim perhaps overlooked others like Wallis, whose idea for a separate building for recoverable patients, proposed in 1894, was also completed in 1900. Yet more importantly, alienists were clearly simultaneously sharing ideas through asylum visits and publications, with practical consequences on the organisation of new asylum buildings.

Planners, however, continued to disagree over the appropriate place for convalescents within the asylum. Later LCC asylums at Horton (1902) and Long Grove (1907) incorporated convalescent villas, yet it is nevertheless notable that planners continued to advocate alternative arrangements in this period. In his plans for what became the Maudsley Hospital (1923), Frederick Mott in 1912 recognised 'the advantage of having separate buildings for convalescent cases', yet opted instead for their 'segregation' in a dormitory in the main building.¹⁵⁵ The Maudsley was arguably an exceptional case, because it had been planned in 1907 as a hospital devoted to early and treatable cases.¹⁵⁶ The whole hospital, therefore, to some extent was planned for similarly 'recoverable' cases to the

¹⁵³ C.C. Easterbrook, 'The New Hospital at Ayr Asylum', *Journal of Mental Science* (July 1907), pp. 249-55.

¹⁵⁴ H. Hayes Newington, 'The Plans of a New Asylum for East Sussex', *Journal of Mental Science* **46** (October 1900), pp. 674, 678.

¹⁵⁵ LMA, LCC, Asylums Committee, Accommodation Sub-Committee, Special Housing and Treatment of Lunatics Sub-Committee, *Minutes*, 17 June 1912, p. 24.

¹⁵⁶ Edgar Jones, Shahina Rahman, and Robin Woolven, 'The Maudsley Hospital: Design and Strategic Direction, 1923-1939', *Medical History* **51** (July 2007), pp. 358-60.

smaller reception hospitals built within asylums elsewhere, with consequently less pressure for distinct sections on the basis of curability. Even so, Mott's willingness to place convalescents within the same building as acute recent cases indicated a return to the sort of unitary hospitals planned elsewhere in the 1890s. Other asylums similarly planned without convalescent villas in the immediate pre-war period, such as Netherne (Surrey: 1909), and Gateshead (1913) would later add these units in the 1920–30s. Such additions provide an indication both of the lack of uniformity in planning for asylum convalescence before 1919 and the extent to which they became an expected part of institutional accommodation after this date.

Official pressure proved important to the spread of convalescent villas, both through the BoC (see Chapter Two) and public inquiries. The publication of Montagu Lomax's *Experiences of an Asylum Doctor* in 1921 led to Parliamentary questions on its 'grave charges', considerable debate in the popular press, and ultimately two official inquiries into the state of asylums.¹⁵⁷ The first of these, the Cobb Committee (1921–23) concluded that it did 'not consider mental hospitals deficient' in 'half-way discharging wards'.¹⁵⁸ Historians have questioned, however, the impartiality of the Committee's more general defence of the *status quo* in asylums, which Nick Crossley has suggested represented a 'bungled attempt to calm public concern'.¹⁵⁹ The report of the Macmillan Commission (1924–26), which conducted a more far-reaching survey of asylum administration in England

¹⁵⁷ 'Parliamentary News', *Journal of Mental Science* **67** (October 1921), p. 571; T.W. Harding, "'Not Worth Powder and Shot": A Reappraisal of Montagu Lomax's Contribution to Mental Health Reform', *British Journal of Psychiatry* **156** (1990), pp. 180-1.

¹⁵⁸ *Report of the Committee on the Administration of Public Mental Hospitals* (London: H.M. Stationary Office, 1922), pp. 67-8.

¹⁵⁹ Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health* (London and New York: Routledge, 2006), p. 60; Harding, 'Powder and Shot', pp. 180, 185.

and Wales, certainly cast doubt on the sufficiency of existing convalescent accommodation. While the Commission recognised that ‘many’ hospitals had separate blocks for convalescents, it still felt it necessary to recommend their further construction as a ‘half-way house out’ from the asylum.¹⁶⁰ Asylum superintendents who participated in the Commission’s proceedings contributed their perspectives on the utility and desirability of particular forms of convalescent accommodation. Although the *JMS* featured less on asylum design in this period, official inquiries in the 1920s provided a further forum for superintendents to debate and discuss the ideal place for convalescents. G.F. Barham (Superintendent, Claybury, LCC), for instance, indicated his dissatisfaction with existing admission wards, which he felt were ‘too much in the main building’. Barham’s positive response to the Commission’s suggestion that he might in future keep a ‘small class of convalescent patients’ separately, indicates how psychiatrists maintained and contributed their own views on asylum reform.¹⁶¹

In certain important respects, these minutes suggest that perceptions of convalescence had changed remarkably little from the mid-nineteenth century. Barham characterised the convalescent patient as ‘of course... companionable’, which perhaps suggests cooperative behaviour lay at the core of the prognostic procedure, rather than any clinical assessment.¹⁶² As Chapter Three explores, the voluntary MACA also adjudged convalescence on the basis of sociability in this period. Erving Goffman’s claim in the 1960s

¹⁶⁰ *Report of the Royal Commission on Lunacy and Mental Disorder* (London: H.M. Stationary Office, 1926), pp. 80, 92-3.

¹⁶¹ *Minutes of Evidence Taken before the Royal Commission on Lunacy and Mental Disorder* (London: H.M. Stationary Office, 1927), G.F. Barham (Medical Superintendent, Claybury), interviewed 13 January 1925, p. 309.

¹⁶² *Ibid.*

that convalescence in the mental hospital simply reflected socially normative behaviour, is therefore perhaps to some extent also observable over the nineteenth and early twentieth century.¹⁶³ Indeed, Barham's emphasis on companionability, and the MACA's emphasis on sociability in convalescence, closely resembles the Tukes' moral assessments of convalescence in the early nineteenth century, on the basis of 'common enjoyment'. In each era, the patient's convalescence was assessed according to their ability to join in with others and relate easily with those around them. More than this, convalescence also arguably continued to act as a measure of how far patients fitted in, and further operated to encourage conformity. Hilary Marland has suggested that asylum superintendents assumed authority over nineteenth-century convalescents, which they refused to release until they had attained 'full convalescence'.¹⁶⁴ Such a didactic and parental view of the recovering patient is equally evident in J.R. Lord's subsequent claim in 1930 that mental hospitals helped the convalescent by 'remoulding... character and the consolidation of the shattered personality'.¹⁶⁵ As in the nineteenth century, therefore, Lord and Barham in the interwar period continued to regard convalescence as a phase of education back to normative adult standards of behaviour.

The extent to which superintendents had approached consensus on the value of mental hospital convalescence is discernible in a statement the RMPA published in response to the *Macmillan Report*. In particular, the RMPA contested the Macmillan Commission's interpretation of the function

¹⁶³ Goffman, *Asylums*.

¹⁶⁴ Marland, *Dangerous Motherhood*, pp. 133, 166.

¹⁶⁵ J.R. Lord, "'After-Care" and other Aspects of Social Service as an Adjunct to Mental Treatment', *Journal of Mental Science* **76** (October 1930), p. 623.

of mental convalescence as a legal safeguard; instead, the Association claimed the 'real purpose' of convalescent accommodation was to 'test the extent of convalescence'. Beyond such assertions of therapeutic and medical intent, the RMPA went further, and described convalescence as a two-phase process that spanned institution and society. Its description of 'wards and villas' for convalescents hints at a continued diversity of approach to mental hospital accommodation in this period, which the BoC had also recently identified in the mid-1920s (see Chapter Two). Yet the RMPA's commitment to an initial phase of mental hospital convalescence that as far as possible replicated 'the patient's home and outside life', and subsequent trial period of convalescence in the community, does suggest it clearly conceived its continuance from institution, and into the community.¹⁶⁶ As the representative body of British psychiatrists, the RMPA claimed to reflect a broad consensus amongst psychiatrists on the purpose of convalescence. Its comments therefore reflect a wider agreement amongst psychiatrists by this date on the co-extensiveness of convalescence across institutional and community boundaries. Alienists became further involved in convalescent care that spanned asylum and home through the MACA's committee, which organised convalescence for trial and early care patients (see Chapter Three). In contrast to previous generations of asylum planners, therefore, it appears that alienists by the 1920s were both more vocal and clearer on the functions mental convalescence should serve.

What is perhaps most noticeable about the Royal Commission's evidence, in contrast to previous eras, is the extent to which recent

¹⁶⁶ 'The Report of the Royal Commission on Lunacy and Mental Disorder', *Journal of Mental Science* 72 (October 1926), pp. 604-5.

admissions and convalescent cases were viewed as part of the same category of 'recoverable' patients. Thus, respondents for the LCC variously stated that paired units for recent admissions and convalescents would collectively ensure these patients remained 'entirely separate from the main building' (Mapother), and 'never came into contact' (Barham) and would 'never mix' (Mott) with its inhabitants.¹⁶⁷ This established a clearer division between the main asylum for chronic patients, and smaller and overtly curative admission and convalescent units for 'recoverable' cases. Concern that other asylum patients might threaten the health of improved convalescents was far from new. Browne, Conolly and Bucknill had all suggested that convalescents needed shielding from other acute and chronic asylum inmates. The difference from the late nineteenth century lay in a greater emphasis on the removal of recoverable patients from the maddening and stigmatised environment of the central asylum building. Historians have observed the severe constraints that the Lunacy Act of 1890 placed on the curative ambitions of superintendents.¹⁶⁸ Others, such as Mathew Thomson and Akinobu Takabayashi, have also suggested that alienists had increasingly focused on ways to improve early treatment.¹⁶⁹ It

¹⁶⁷ *Minutes of Royal Commission on Lunacy*, G.F. Barham (Medical Superintendent, Claybury), interviewed 13 January 1925, p. 299; Edward Mapother (Medical Superintendent, Maudsley), interviewed 22 June 1925, p. 819; Frederick Mott (Neuropathologist, Maudsley Hospital; representative for RMPA as its President), interviewed 4 May 1925, p. 725.

¹⁶⁸ The Lunacy Act, 1890, centred the process of admission to public mental hospitals on a judicial process, administered through justices of the peace, and only secondarily certified through two qualified medical practitioners. See Anne Rogers and David Pilgrim, *Mental Health Policy in Britain: A Critical Introduction* (Basingstoke and London: Macmillan, 1996), pp. 60-1; Roy Porter, 'Madness and its Institutions', in Andrew Wear (ed.), *Medicine in Society: Historical Essays* (Cambridge: Cambridge University Press, 1992), p. 246; Kathleen Jones, 'Law and Mental Health: Sticks or Carrots?', in German E. Berrios and Hugh Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Gaskell, 1991), p. 97.

¹⁶⁹ Mathew Thomson, *Psychological Subjects: Identity, Culture and Health in Britain* (Oxford and New York: Oxford University Press, 2006), p. 186; Akinobu Takabayashi, 'The Political Economics of English Psychiatry in the Early Twentieth Century' (unpublished PhD thesis, University College London, 2008).

seems likely that superintendents who were legally prevented from making their institutions more open to recent cases in the absence of voluntary treatment before 1930, focused instead on those at least most recently admitted. In the attention they drew to the high degree of separation between the 'recoverable' and other patients, superintendents thereby carved out and promoted a site for overtly curative 'early' treatment under their jurisdiction.

It is possible to see this invocation of convalescence by superintendents and by the BoC (see Chapter Two), as part of what Akinobu Takabayashi has called a 'political rhetoric'. Convalescence reinforced the medical claims of psychiatrists in this period, in much the same way that Takabayashi has argued psychiatrists focused on early treatment 'to counter the ill-effects' of the 1890 Lunacy Act.¹⁷⁰ The RMPA's challenge to the Macmillan Commission's legalistic interpretation of convalescence, and its emphasis instead on convalescence as a phase of 'testing' that required skilled observation, directly challenged the judicial premises of existing lunacy legislation.¹⁷¹ Indeed, as this chapter has argued (and Chapter Two explores further) it is possible to see the convalescent villa as increasingly part of a material and rhetorical equation between mental hospital treatment, convalescence, and early treatment. An example of this is J.R. Lord's 1930 paper on the implications of the Mental Treatment Act to aftercare, which presented mental hospital convalescence as a form of prophylaxis. The introduction of temporary and voluntary treatment with this Act, Lord argued, would help mental hospitals obtain 'a first place in preventive medicine'. Lord

¹⁷⁰ Takabayashi, 'Political Economics of English Psychiatry', p. 246.

¹⁷¹ 'The Report of the Royal Commission on Lunacy and Mental Disorder', *Journal of Mental Science* **72** (October 1926), p. 605.

argued that mental hospitals contributed to prevention through an initial phase of hospitalised 'rehabilitation', which extramural convalescent home then concluded.¹⁷² Such views matched Lord's concern stated elsewhere that mental hospitals should be 'part and parcel of everyday life in the community'.¹⁷³ Like the RMPA, therefore, Lord framed mental hospital convalescence as an ordinary, progressive, and overtly medical part of recovery from mental illness.

Lord's secretarial responsibilities for the National Council for Mental Hygiene (NCMH: 1923), and position at an LCC asylum (Horton), certainly placed him at the vanguard of a preventive conception of psychiatric treatment and recovery. Such ideas also became increasingly commonplace in the interwar period, however, as Chapters Two and Three will suggest, as part of a more general movement to integrate the related practices of convalescence in mental hospitals and the voluntary sector. Indeed, Lord spoke on behalf of the broader profession when he represented the RMPA's views on convalescent villas to the Macmillan Commission in 1925. The responses of Lord, and fellow RMPA representative Frederick Mott, suggest that they regarded paired admission and convalescent units as a remedy to the poor public image of the asylum. Mott felt conjoint acute and convalescent blocks would ensure 'the public would then differentiate at once' between these 'clinic' services for recoverable patients and the 'chronic hospital' for

¹⁷² Lord, 'After-Care', pp. 623, 631.

¹⁷³ J.R. Lord, *Mental Hospitals and the Public: The Need for Closer Co-operation* (London: Adlard and Son, 1927), p. 24. This was in turn re-worded from an earlier pamphlet. See J.R. Lord, *Social Workers and the Insane* (London: Adlard and Son and West Newman, 1923), p. 15.

incurable residents.¹⁷⁴ In response Lord went further and suggested that as well as being placed at a distance these units might be given ‘fancy names’, so recent patients might ‘not be counted as having been to the chronic insane asylum’.¹⁷⁵ As such, both Mott and Lord interpreted the mental hospital convalescent villa as a means to enhance the image of the broader institutions in which they were built. In 1934 Northampton’s superintendent Daniel Rambaut would claim the separately-named admission hospital (Wantage House) and convalescent villas (the Rowans, Merchiston) completed in 1927 represented ‘self-contained facilities’. Like Mott and Lord, Rambaut strategically focused upon the distinctiveness of these additions with their atmosphere of ‘therapeutic activity, rather than of control under legal safeguards’, to emphasise the curative credentials of his institution.¹⁷⁶

It appears, however, that some superintendents may have challenged the view that mental hospital convalescent villas provided the best hope for sustained recovery. Mott in particular seems to have regarded onsite mental hospital facilities for recent cases as a viable but inferior option to out-patient clinics associated with general hospitals. His testimony to some extent supports Andrew Scull’s claim that psychiatrists in the twentieth century increasingly looked beyond the asylum for new fields of professional practice.¹⁷⁷ Where clinics were impractical Mott advised the construction of conjoint acute and convalescent blocks ‘preferably outside the asylum grounds’; their construction within asylum estates was therefore in his view

¹⁷⁴ *Minutes of Royal Commission on Lunacy*, Frederick Mott (President, RMPA), interviewed 4 May 1925, p. 725.

¹⁷⁵ *Ibid.*, J.R. Lord (RMPA representative), interviewed 4 May 1925, p. 725.

¹⁷⁶ Daniel Rambaut, ‘Some Recent Forms of Mental Treatment’, *Journal of Mental Science* **80** (October 1934), p. 636.

¹⁷⁷ Andrew Scull, ‘Psychiatry and Social Control in the Nineteenth and Twentieth Centuries’, *Social History of Medicine* **2** (June 1991), pp. 162, 165.

the least attractive means of reform. Pragmatism seems to have underpinned the comparatively lukewarm support the RMPA's delegation showed for early treatment within mental hospitals. While Mott acknowledged clinics might not be possible everywhere, J.R. Lord stated that when choosing between clinics or improved mental hospital facilities for early treatment, they could not 'as an association recommend things we think impracticable economically'.¹⁷⁸ From this perspective, the mental hospital convalescent villa might be seen as a compromise, advocated due to the financial and practical unfeasibility of sufficient clinics to meet demand for early treatment. Others such as Edwin Goodall told the Macmillan Commission that he would ideally have no recoverable patients within the asylum. Upon further questioning, however, Goodall conceded that he did 'not think clinics, however abundant, would be able to deal with all these... cases'.¹⁷⁹ Whilst this admitted a role for mental hospitals in recovery, like Mott, Goodall also gave first preference to early treatment outside the asylum.

It is perhaps significant that the RMPA chose both Mott and Goodall to act as delegates to the Macmillan Commission, in a sign that the profession they represented increasingly looked beyond mental hospitals as the primary locus of recovery. Louise Westwood has characterised Mott and Goodall as part of a wider group of 'more enlightened' psychiatrists that emerged from their experiences in the treatment of war neuroses to become advocates of clinic-based early treatment in peacetime. The establishment of clinics after

¹⁷⁸ *Minutes of Royal Commission on Lunacy*, Frederick Mott (President, RMPA) and J.R. Lord (RMPA representative), interviewed 4 May 1925, pp. 719, 725.

¹⁷⁹ *Ibid.*, Edwin Goodall (RMPA representative), interviewed 4 May 1925, pp. 710, 712.

1919 at Oxford, Goodall's hospital at Cardiff, and the Maudsley Hospital where Mott worked from 1923 put into practice an approach to early treatment that Westwood and Mathew Thomson have traced back to at least the late nineteenth century.¹⁸⁰ The clinics at Cardiff and the Maudsley in each case offered further support to convalescents. So too, Goodall in particular pressed for the establishment of voluntary cottage homes in South Wales comparable to those found across south-east England used regularly by the Maudsley and other LCC mental hospitals.¹⁸¹ As such Mott and Goodall had already participated in the development of a more community-centred approach to convalescence, which they were then empowered to represent on behalf of the countries' psychiatrists. Their evidence suggests that the convalescent villa even at the peak of its visibility in the 1920s and 1930s represented an inferior option to at least some eminent figures in psychiatry.

Even so, most psychiatrists do seem to have supported the convalescent villa as an appropriate building-type to commence patients' restitution to health. Less frequently, planners followed the BoC's interest in convalescent accommodation as a means of more cost-effectively accommodating additional patients, although therapeutic arguments now predominated over managerial imperatives. Thus, Edward Mapother (Superintendent, Maudsley) and J.R. Lord both independently commended

¹⁸⁰ Westwood, 'Avoiding the Asylum', pp. 164, 166; Thomson, *Psychological Subjects*, p. 186.

¹⁸¹ 'Medico-Psychological Association', *Journal of Mental Science* 69 (October 1923), p. 551; *Minutes of Royal Commission on Lunacy*, Edwin Goodall, interviewed 4 May 1925, p. 743; Edwin Goodall, 'Mental and Allied Disorders (Psychoses and Psycho-neuroses) from the Points of View of Scientific Investigation, Early Care and Treatment, and Education of Students', in *Report of a Conference on Mental Deficiency held at Central Hall, Westminster, London, S.W. on Thursday and Friday December 2nd and 3rd, 1926* (London: Central Association for Mental Welfare, c.1926-7), p. 71.

convalescent homes as a means of freeing beds in the central asylum that could then be occupied by acute patients. Mapother in particular contrasted the cost of beds in 'expensive hospitals' against 'cheap' convalescent villas.¹⁸² Later, in 1939, the Feversham Committee on voluntary mental welfare services would take such ideas further, and recommend the extension of voluntary aftercare for convalescents, in order to resolve the 'double-burden' that continued hospitalisation placed upon both the patient and those who had to fund their stay.¹⁸³ Such arguments reflect a sustained pragmatism in the reasons asylums planners chose some forms of convalescent accommodation over others, little different from that advocates of 'cottages' for convalescents had raised from the 1850s. Mary Fisher has suggested that the development of psychiatric social work and increased use of parole in the interwar period perhaps derived from a desire to free up expensive mental hospital beds.¹⁸⁴ On the basis of the Macmillan Commission's evidence, it seems likely that convalescent villas, and more especially voluntary cottage homes, at least partly fulfilled a similar function.

Although not all hospitals had adopted the BoC's preferred supplementary early treatment centres by 1939 as Chapter Two explores, the idea that mental hospitals should convalesce patients soon after admission had become a commonplace amongst asylum planners. Chronic patients and those requiring palliative or long-term care and treatment, Vicky Long has argued, may have become more susceptible to stigmatisation due to the displacement of curative care into separate admission and

¹⁸² *Report of the Macmillan Commission*, Edward Mapother, interviewed 22 June 1925, p. 820; Lord, 'After-Care', p. 623.

¹⁸³ *The Voluntary Mental Health Services: The Report of the Feversham Committee* (London: Feversham Committee, 1939), p. 95.

¹⁸⁴ Fisher, 'Getting Out of the Asylum', pp. 207, 250, 267.

convalescent units.¹⁸⁵ This had been a concern amongst some early twentieth-century asylum planners such as R.H. Steen (Superintendent, City of London), who argued in 1900 that by concentrating on hospitalised patients, there was ‘a liability that the chronic patient may be neglected’.¹⁸⁶ The few authorities such as the LAB that established entirely separate asylums for chronic patients therefore faced criticism.¹⁸⁷ By focusing on the apparent modernity of the admission hospital and convalescent villa in the interwar period, asylum planners conveniently overlooked the continuance alongside them of older asylum buildings for the chronic and acute. As Emeritus Professor of Psychological Medicine at KCL, Steen would later claim in 1927 that ‘in some respects mental hospitals are leading the way’, and cited the villa system as an example of its innovativeness compared with general hospitals.¹⁸⁸ This desire to be seen as comparable with general hospitals, as unexceptional and overtly medical institutions, appears to have underlain a resurgence of interest amongst asylum planners in the mental convalescent. Due to the impracticality of rebuilding entire institutions, asylum planners seem to have settled on the paired admission hospital and convalescent villa, as part of a broader contemporary interest in preventive medicine. That it served to widen the gap between the curable and incurable – in the process repositioning convalescence within the realm of pseudo-preventive medicine – merely realised W.A.F. Browne’s dictum of 1837 that

¹⁸⁵ Long, ‘Changing Public Representations of Mental Illness’, p. 119.

¹⁸⁶ Steen, ‘Evolution of Asylum Architecture’, p. 96.

¹⁸⁷ Rhodes, ‘Suitable Accommodation’, p. 684. This followed John Conolly’s earlier belief in the 1840s that incurable inmates ‘should not be treated as a case apart’, although others like J.T. Arlidge had been happy to condone such a separation in the 1850s. See Conolly, *Construction and Government*, pp. 4-5; Arlidge, *State of Lunacy*, pp. 127-9.

¹⁸⁸ Robert Hunter Steen, *The Modern Mental Hospital* (London: Methuen, 1927), p. 53.

'to the curable and convalescent... our greatest care ought to be consecrated'.¹⁸⁹

5. Conclusion

This chapter has addressed two related themes: firstly, the extent of provision made for convalescence in the asylum before 1939, and secondly, what this suggests about changing ideas on the purpose of managed convalescence as part of institutional treatment. Across a broad period, from at least the 1780s to the 1930s studied in this thesis, asylum planners continued to envisage a subset of convalescent patients. Separate references to 'convalescent' patients, differentiated from other orderly patients, suggest that asylum planners for over 150 years distinguished between the increasingly well and the merely well-behaved. Even so, nineteenth-century asylum plans often appear to have housed these patients together on the basis of good behaviour, regardless of their prognosis. Despite some specific arguments on the benefits convalescents might gain from cottage plans, particularly from the 1850s, it is noticeable that across much the nineteenth century similar buildings were also provided to patients with apparently poorer prognoses. This allocation of accommodation primarily on the basis of behaviour suggests that Erving Goffman's thesis – that convalescence in 1960s mental hospitals corresponded to little more than behavioural conformity – might be read back further into the nineteenth century.¹⁹⁰ Based on the reasons nineteenth-century asylum planners gave

¹⁸⁹ Browne, *What Asylums Ought to Be*, p. 200.

¹⁹⁰ Goffman, *Asylums*, pp. 252, 266.

for separately managed convalescent accommodation, only references to the increased liberty cottages offered patients served to distinguish them from comparable units for other well-behaved patients. In this respect, it is certainly possible, as Barry Edington has argued, to perceive the lasting influence of the Tukes' moral therapy on nineteenth-century asylum design.¹⁹¹ Indeed, even into the twentieth century, superintendents considered the extent of patients' convalescence on Tukean principles of sociability and responsiveness.

For much of the nineteenth century, asylum planning for convalescence appears to have been only tangentially related to the prognosis of improved patients. Instead, it is easier to discern the managerial, economic and palliative impulses that Chris Philo has proposed characterised asylum planning in the late nineteenth century.¹⁹² Authors in this period repeatedly evaluated convalescent accommodation according to cost, and although some chose to prioritise homely accommodation, there is little sense this was primarily devised as therapy. Chronic patients widely benefited from similar accommodation, and, in practice, it appears planners proved content to substitute these patients into wards previously occupied by convalescents. Moreover, planners in the 1840s, and again in the 1880–90s, reverted to the placement of convalescents in wards within central asylum buildings. This corresponds with Jeremy Taylor's claim that asylum planners remained concerned with classification, but further suggests that their ideas on the appropriate place of convalescents remained unsettled, and perhaps less important than the reform of asylums as a whole. Instead, it appears

¹⁹¹ Edington, 'Influence of the York Retreat', p. 92; Edington, 'Space for Moral Management'.

¹⁹² Philo, 'Scaling the Asylum', p. 117.

others concerns regulated their choices over where, and if, to provide convalescents with separate accommodation. Throughout the period, overcrowding seems to have offered an incentive for planners to consider adding detached cottage or villa units, with convalescents often the beneficiaries. Planners weighed the cost of such additions against their positive therapeutic effect on residents, but behind each appears to have stood a continual need for further accommodation to keep pace with ever-rising numbers of admissions. As only one class amongst many, convalescents were subject to the same institutional imperatives that regulated the design of institutions for all patients.

Cottage-like units also provided a convenient way for asylum planners to imbue large institutions with a more homely feel. A connection between domesticity and treatment is observable to some extent from the eighteenth century, when Barry Edington has argued that the Tuke's and architect John Bevans 'attempted to reproduce the family home' in their design for the Retreat.¹⁹³ Cumulative overcrowding and the increasing scale of asylums during the course of the nineteenth century made it more difficult for planners to claim centralised asylums could offer such homeliness. Whilst the interior furnishings of wards within a centralised asylum might also be made homelike, the comments of those such as John Bucknill, Henry Maudsley, and Ebenezer Toller indicate that alienists increasingly looked to smaller satellite units to foster a more recognisably domestic environment. The timing of their appeals and the concern that those such as Toller and Maudsley showed for public attitudes, supports Felix Driver's thesis that

¹⁹³ Edington, 'Design of Moral Architecture', p. 113.

cottage plans marked a reaction against the overbearing institutional appearance of asylums.¹⁹⁴ The construction of home-like cottages addressed both the practical need for more asylum accommodation and a recurrent concern amongst planners from Conolly in the 1830s to Maudsley in the 1870s on the potentially detrimental influence asylums themselves had upon mental health. Only gradually over the late nineteenth- and early twentieth century, however, did asylum planners begin to place particular emphasis on the desirability of distinct 'half-way homes' for convalescents, as a part of the therapeutic process of recovery. During this period this specific function becomes more visible and clearly elaborated in asylum planners' recreation of the asylum as a potential home-from-home for the probationary convalescent.

It appears that asylum planners from the late nineteenth century converged on the convalescent villa primarily because it conformed with alienists' preferred emphasis on the asylum as a place of early treatment. Victorian asylums had perhaps already to some extent differentiated between patients on the basis of their prognosis. The notoriety of the 'back wards' perhaps reinforced a sense of recoverable and irrecoverable zones within centralised institutions in the nineteenth century.¹⁹⁵ So too, it is possible to perceive continuity between the sort of short-term respite care Hilary Marland has suggested asylums offered cases of puerperal insanity in the nineteenth century, and the respite function Diana Gittins has claimed

¹⁹⁴ Driver, *Power and Pauperism*, pp. 66-7.

¹⁹⁵ Porter, *Madness*, p. 158.

convalescent wards provided in the twentieth century.¹⁹⁶ Nevertheless, asylum planners in the twentieth century increasingly highlighted a connection between convalescence and recent admission. The placement of convalescent villas alongside admission hospitals at the LCC's asylums developed in tandem with the authority's unsuccessful efforts to establish reception houses for mental patients outside the asylum from the 1890s. Although overcrowding and international templates provided impetuses for their initial development, asylum planners between the 1900s and 1920s seem to have laid most emphasis on the usefulness of convalescent villas as part of an approach to early treatment. This chapter has suggested that such ideas emerged only slowly from the 1890s to the 1920s, as part of a political rhetoric that served to align the mental hospital with new approaches to early treatment in the community.

In turn, this facilitated a reinvention of the asylum into the curative 'mental hospital', by focusing on a small subset of 'recoverable' patients, and the reformed arrangements for their treatment. The effect of this strategic focus on the most curable, as Vicky Long has argued, may have been to maroon the chronic patients beyond that part of the asylum associated with cure. As Long has suggested, this perhaps reinforced the stigmatisation of the majority of hospital residents, even as it enhanced the visibility and separateness of the recoverable.¹⁹⁷ This allowed asylum planners to claim that these institutions contributed to the cure of recent cases of mental disorder, and to reinvent convalescence as an adjunct to preventive early

¹⁹⁶ Marland, *Dangerous Motherhood*, p. 165; Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London and New York: Routledge, 1998), pp. 40-43, 131.

¹⁹⁷ Long, 'Public Representations of Mental Illness', p. 191.

treatment. Compared with the lack of clarity Chris Philo had perceived over the difference in nineteenth-century plans for chronic and convalescent cottages, twentieth-century asylum planners defined convalescence convalescent villas more clearly as functionally distinctive additions.¹⁹⁸ While it appears some psychiatrists might have ideally preferred a concentration of resources into separate clinics, hospitals and homes devoted entirely to convalescents and early cases of mental disorder, the convalescent villa represented a pragmatic response to asylum reform. In claiming that these units would help successfully treated recent admissions recuperate from their illnesses, psychiatrists also served to rehabilitate the image of the mental hospital, and their place within the medical profession.

¹⁹⁸ Philo, 'Enough to Drive One Mad', p. 279.

Chapter Two: The Mental Hospital Convalescent Villa, 1919–39

1. Introduction

Edward Shorter and Andrew Scull have each proposed that interwar psychiatrists increasingly abandoned mental hospitals for community practice, in response to the poor professional and public reputation of existing institutional treatment. According to Scull and Shorter, the obsolescence of mental hospitals was inscribed in their stigmatised image, as much as their function. Scull has claimed that by the late nineteenth century, asylums already lacked popular and professional credibility, and were at best regarded as refuges and at worst houses of detention.

¹ By the interwar period, according to Shorter, asylums were viewed as ‘the very mirror of desolation’; a pessimistic view that, like Scull’s, suggests a gradual loss of faith in the asylum’s curative potential.² Consequently, these scholars have implied that any historical search for developments in psychiatric approaches to convalescence should follow the gaze of disillusioned interwar psychiatrists and look beyond the asylum. Roy Porter has at least questioned whether twentieth-century mental hospitals have merited their historiographical reputation as ‘entirely paralysed’ institutions.³ The question itself attests, however, to a prevalent historical perception that mental hospitals in this period were characterised by inertia and

¹ Andrew Scull, *The Insanity of Place, the Place of Insanity: Essays on the History of Psychiatry* (London and New York: Routledge, 2006), p. 25.

² Edward Shorter, *A History of Psychiatry* (New York: John Wiley, 1997), pp. 191-2; Andrew Scull, *Decarceration: Community Treatment and the Deviant* (Cambridge: Polity Press, 1984 [1977]), pp. 66, 107; Andrew Scull, ‘Psychiatry and Social Control in the Nineteenth and Twentieth Centuries’, *Social History of Medicine* 2 (June 1991), pp. 162, 165.

³ Roy Porter, ‘Foreword’, in David H. Clarke, *The Story of a Mental Hospital: Fulbourn, 1853-1983* (London: Process Press, 1996), p. ix.

custodialism.⁴ So too, Porter has concluded that whilst mental hospitals became more open and therapeutically experimental institutions, this represented little more than a 'holding operation', again suggesting that the most notable developments were taking place elsewhere.⁵ Instead, asylums after 1914 have often been contrasted with the development of clinics and institutions such as the Maudsley, and adjudged moribund in comparison.⁶ Where historians have identified change, this has referred primarily to a shift in rhetoric rather than in institutional design or service delivery.⁷ Consigning mental hospitals to a secondary place in her search for pioneering approaches to early twentieth-century mental healthcare, Louise Westwood has concluded that in practice 'a more enlightened, progressive, humanitarian and scientific approach was being taken outside the asylum system'.⁸

⁴ Richard Hunter and Ida MacAlpine, *Psychiatry for the Poor: A Medical and Social History* (London: Dawson's, 1974), p. 158; William Parry-Jones, 'The Model of the Geel Lunatic Colony and Its Influence on the Nineteenth-Century Asylum System in Britain', in Andrew Scull (ed.), *Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era* (Philadelphia, PA: University of Philadelphia Press, 1981), p. 213; Anne Rogers and David Pilgrim, *Mental Health Policy: A Critical Introduction* (London and Basingstoke: Macmillan, 1996), p. 62; Liam Clarke, 'The Opening of Doors in British Mental Hospitals in the 1950s', *History of Psychiatry* 4 (December 1993), p. 530.

⁵ *Ibid*; Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), pp. 208-9.

⁶ Harriet Richardson, 'Mental Hospitals', in Harriet Richardson (ed.), *English Hospitals, 1660-1948: A Survey of their Architecture and Design* (Swindon: Royal Commission on the Historical Monuments of England, 1998), pp. 180-1; Vicky Long, 'Changing Public Representations of Mental Illness in Britain, 1870-1970' (unpublished PhD thesis, University of Warwick, 2004), p. x; Edgar Jones, Shahina Rahman, and Robin Woolven, 'The Maudsley Hospital: Design and Strategic Direction, 1923-1939', *Medical History* 51 (July 2007), pp. 357-8.

⁷ Rogers and Pilgrim, *Mental Health Policy*, pp. 62-3; Mathew Thomson, 'Constituting Citizenship: Mental Deficiency, Mental Health and Human Rights in Interwar Britain', in Christopher Lawrence and Anna K. Mayer (eds), *Regenerating England: Science, Medicine and Culture in Inter-War England* (Amsterdam and Atlanta, GA: Rodopi, 2000), p. 241. In contrast, Lindsay Prior has suggested that a rhetorical shift from 'asylum' to 'mental hospital' mirrored a substantive and intentional practical transition to curative treatment. See Lindsey Prior, *The Social Organization of Mental Illness* (London; Thousand Oaks, CA; and New Delhi: Sage, 1993), pp. 29-31.

⁸ Louise Westwood, 'A Quiet Revolution in Brighton: Dr Helen Boyle's Pioneering Approach to Mental Health Care, 1899-1939', *Social History of Medicine* 14 (December 2001), p. 439;

It is perhaps unhelpful, however, to view developments in mental hospital practice solely in comparison with community-based initiatives. Out-patient clinic services remained highly localised, even by 1939, so in some areas the comparison poorly reflects the options available to patients in practice.⁹ For those without easy access to out-patient clinics, or already in institutional care, changes within mental hospitals would have had a greater impact than potentially more pioneering experiments in the community beyond their reach. Furthermore, institutional case-histories suggest that many hospitals did change significantly in ways that bear out J.L. Crammer's claim that mental hospitals 'began to take a very new shape' in the 1930s.¹⁰ Diana Gittins has argued the interwar years at Severalls Hospital (1913) represented 'a heyday... at least in relation to new buildings'.¹¹ At older institutions too, such as Claybury (1893), Eric Pryor has indicated how newly-opened admission and convalescent units allowed less disturbed cases to remain separate from the central institution until their discharge.¹² Certainly, some institutions such as Buckingham and Norfolk changed relatively little, which Steven Cherry has attributed to financial constraints, bureaucratic torpor, and local managerial obstructionism.¹³ Even so, Alys Levene's (*et al.*) analysis of municipal expenditure suggests that mental

Louise Westwood, 'Avoiding the Asylum: Pioneering Work in Mental Health Care, 1890-1939' (unpublished PhD thesis: University of Sussex, 1999), p. 4.

⁹ Westwood, 'Avoiding the Asylum', p. 3; Mathew Thomson, *Psychological Subjects: Identity, Culture and Health in Britain* (Oxford and New York: Oxford University Press, 2006), p. 190.

¹⁰ J.L. Crammer, 'English Asylums and English Doctors: Where Scull is Wrong', *History of Psychiatry* 5 (March 1994), p. 110.

¹¹ Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London and New York: Routledge, 1998), p. 26.

¹² Eric H. Pryor, *Claybury: A Century of Caring* (London: The Mental Health Care Group, Forest Healthcare Trust, 1993), p. 80.

¹³ Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum, St Andrew's Hospital, 1810-1998* (Woodbridge and New York: Boydell Press, 2003), p. 173; John Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum: St John's* (London: Gaskell, 1990), pp. 142-3.

hospitals were one of the few public services to increase their budgets between the wars.¹⁴ Some mental hospitals at least allocated significant sums for substantial remodelling work, as at Denbigh, Derby County and Durham, which were among those to construct detached admission hospitals and convalescent blocks.¹⁵ Far from ‘paralysed’ relicts of Victorian planning, therefore, mental hospitals continued to evolve in the early twentieth century in ways that historians have only rarely considered on their own terms.

It has hitherto remained unsettled how far mental hospitals adapted to accommodate the ‘recoverable’ that this thesis argues became a key focus for institutional reform after 1919. Historians of medical architecture have focused principally on pre-1914 plans, and as a result have largely excluded subsequent redevelopments.¹⁶ David Cochrane has more openly discounted the importance of post-1919 villas within London’s asylums, and has simply footnoted that ‘a few villas were added here and there during the 1920s and 1930s’. Instead, Cochrane has primarily framed the era of asylum reform as a primarily ‘Victorian’ phenomenon, which ended with the belated completion of West Park Mental Hospital in 1924.¹⁷ Certainly, as Chapter One has explored, some asylums had already developed separate blocks for

¹⁴ Aylsa Levene, Martin Powell, and John Stewart, ‘Patterns of Municipal Health Expenditure in Interwar England and Wales’, *Bulletin of the History of Medicine* **78** (Fall 2004), p. 652.

¹⁵ Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000* (Cardiff: University of Wales Press, 2003), p. 127; Long, ‘Changing Public Representations of Mental Illness’, p. 119.

¹⁶ Susan Piddock, *A Space of their Own: The Archaeology of Nineteenth-Century Lunatic Asylums in Britain, South Australia and Tasmania* (New York: Springer Verlag, 2007), pp. 128, 136, 154; Bridget Franklin, ‘Hospital – Heritage – Home: Reconstructing the Nineteenth-Century Lunatic Asylum’, *Housing, Theory and Society* **19** (December 2002), pp. 170-1; Jeremy Taylor, *Hospital and Asylum Architecture in England, 1840-1914: Building for Health Care* (London: Mansell, 1991), p. 156.

¹⁷ David Cochrane, ‘“Humane, Economical, and Medically Wise”: The LCC as Administrators of Victorian Lunacy Policy’, in W.F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III: The Asylum and its Psychiatry* (London and New York: Routledge, 1988), pp. 266, 272.

convalescents and other patient classifications during the nineteenth century. So too, as this chapter posits, London had already taken significant steps towards a new, and more fragmented model of institutional design between 1900 and 1919. These were undoubtedly important developments, which to some extent offered a precedent for interwar villas. Nevertheless, to concentrate solely on pre-1914 asylum architecture overlooks the extent to which official bodies, and local authorities such as the London County Council (LCC), presented interwar convalescent villas as part of an overtly 'modern' mental hospital system. Far from simple supplementary structures, as Cochrane has envisaged, this chapter suggests that villas were designed to a specification, intentionally situated, and publicly presented in ways that bodies such as the Board of Control (BoC) claimed benefited the most 'recoverable'. If there were very few mental hospitals without remodelled admission and convalescent accommodation by 1939, as Alexander Walk has suggested, it raises the question: what was their construction intended to achieve?¹⁸

To assess the significance of convalescent villas, this chapter looks at the rhetoric and rationalisation supporting their development, and the extent to which such units were built in practice. As such, it addresses both the ideational and practical importance of convalescent villas as part of a wider representation of the Victorian asylum as modern and overtly medical 'mental hospitals'. Historians such as Andrew Scull, Carla Yanni, and Mathew Thomson have proposed that asylum 'cottage' plans after 1900 did little more than foster an 'illusion of intimacy', which on a more mundane

¹⁸ Alexander Walk, 'Mental Hospitals' in F.N.L. Poynter (ed.), *The Evolution of Hospitals in Britain* (London: Pitman Medical Publishing, 1964), p. 11.

level also helped alleviate chronic overcrowding. Their arguments raise the possibility that detached patient blocks may have been intended as much for a public audience and for managerial purposes as for patients, although Thomson has further suggested that colonies may have served other professional, social and therapeutic agendas.¹⁹ The contrast Niall McCrae has raised between the interwar admission unit's modernity and the 'stultifying' and 'Victorian' asylum estates in which they were situated has highlighted the former's reformist appeal.²⁰ The first section of this chapter considers the extent of the BoC's powers over construction, the extent of their implementation, and the significance of convalescent villas to its policy on mental hospital reform. It further assesses how these villas were organised, and what this suggests about their function. The second part of the chapter then investigates the case of the LCC to explore what determined the form they took in local context.

2. Official Policy on Convalescence within Mental Hospitals

2.1. The Powers and Influence of the Lunacy Commission (1845–1913) and

Board of Control (1913–39)

¹⁹ Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c. 1870-1959* (Oxford: Oxford University Press, 1998), pp. 113-4; Scull, *Decarceration*, pp. 112-3; Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States: Architecture, Landscape and American Culture* (Minneapolis and London: University of Minneapolis Press, 2007), pp. 79, 97, 100.

²⁰ Niall McCrae, "A Violent Thunderstorm": Cardiazol Treatment in British Mental Hospitals', *History of Psychiatry* **17** (March 2006), p. 69.

Founded under the Lunacy Act, 1845, the Lunacy Commission maintained a supervisory and regulatory interest in the construction of asylum buildings.²¹ After the passage of the Mental Deficiency Act, 1913, these responsibilities passed to the Lunacy Commission's successor body, the BoC. Both authorities maintained regulatory control over the administration of English and Welsh lunacy policy, and therefore exerted significant influence over the place designated for convalescents within asylum planning. Powers of asylum inspection made permissive in 1828 and mandatory on an annual basis in 1842 were invested in a central Lunacy Commission under the Lunacy Act of 1845; whilst the related County Asylums Act passed the same year required all counties to provide such asylums. Further Acts in 1890 and 1891 required local authorities to submit a specified portfolio of plans to the Lunacy Commission for all additional asylum buildings.²² Together, these provisions ensured the administrative centralisation of asylum planning through the Lunacy Commission and BoC, even if final approval came from other government departments. Prior to 1919, the right of veto over these plans remained vested in the Home Secretary, and therefore outside the lunacy authorities' direct control. On the transfer of these powers to the newly-created Minister of Health in 1919, the BoC gained more influence.²³

²¹ The Lunacy Act, 1845 established a central Board of Control, while the Lunatic Asylums and Pauper Lunatics Act, 1845, made the provision of asylums in every county a statutory duty. See D.J. Mellett, 'Bureaucracy and Mental Illness: The Commissioners in Lunacy, 1845-90', *Medical History* **25** (July 1981), p. 224.

²² The BoC held these powers under sections 39 and 40 of the Lunacy Act, 1890 and section 254(2) of the Lunacy Act, 1891. See The National Archives [TNA], Lunacy Commission and BoC, circulars, O.E. Dickinson (Secretary, BoC) to visiting committees of all English and Welsh asylums (5 October 1923), 625; Henry Studdy Theobald, *The Law Relating to Lunacy* (London: Stevens and Sons, 1924), p. 682.

²³ Theobald, *Law Relating to Lunacy*; Nicholas Hervey, 'The Lunacy Commission, 1845-60, with Special Reference to the Implementation of Policy in Kent and Surrey, Volume I' (unpublished PhD thesis, University of Bristol, 1987), p. 194, and Volume II, p. 43, n. 20; *Annual Report of the Board of Control for the year 1930* (London: H.M. Stationary Office, 1931), p. 7.

Thereafter, as a subsidiary part of the Ministry of Health, the Board could claim the right to refuse plans, including where proposals ‘took insufficient account of modern therapeutic requirements’.²⁴ Any decision to commence alterations in the first place, however, rested primarily with local authorities, which left the lunacy authorities with a purely advisory remit in the initial instigation of building plans. Indeed, the BoC complained in 1930 that it had ‘never had the power to compel local authorities to provide any buildings which they did not think necessary’.²⁵

The BoC’s efforts to stimulate convalescent villa construction in the interwar period typified the interestedness of the Lunacy Commissioners in the regulation of asylum design. Rules published through the Lunacy Commission in 1846, and revised in 1871, established detailed guidance on asylum construction, even if they remained permissive at least until such time as local authorities submitted plans for approval. In the absence of comprehensive formal powers, the lunacy authorities relied instead on informal methods of persuasion and criticism to coax local councils into making changes. Official circulars on asylum design sent in 1903 and 1923 indicate how jealously the lunacy authorities guarded their powers over planned construction. Both circulars encouraged asylums to seek-out official approval for plans in cases where its necessity was unclear under the Lunacy Acts. The BoC’s 1923 memorandum went furthest, and called for councils to submit plans even for those minor works that technically fell

²⁴ *The Sixteenth Report of the Board of Control for the Year 1929* (London: HM Stationary Office, 1930), p. 7.

²⁵ *Ibid.*

outside statutory regulation.²⁶ In this appeal, the BoC attempted to redefine and enlarge its role beyond the statutory minimum, to cover all aspects of asylum design. The lunacy authorities could apply additional pressure through the practice of annual asylum visitation. Nicholas Hervey has argued that the nineteenth-century Lunacy Commission made ‘ruthless use’ of its yearly inspection reports to pressure institutions into change. The extent to which the lunacy authorities still relied on these methods in the 1930s is hinted at in the 1968 recollections of Isabel Wilson, a former interwar BoC inspector. Wilson claimed that the publication of inspection reports had done a ‘great deal’ to persuade local authorities into compliance with the lunacy authorities’ wishes.²⁷ It was this desire to effect change and reform the mental hospital that makes the BoC such a significant body in the development of the convalescent villa.

Peter Bartlett and Steven Cherry are among those to have emphasised the relative powerlessness of the lunacy authorities to do more than privately and publicly criticise what they perceived as defective institutional design. In particular, Steven Cherry has suggested that the Board’s inspectors became increasingly frustrated in the 1930s at the slow progress made towards the inception of improved admission facilities at Norfolk Mental Hospital.²⁸ In its annual report for 1930, the Board openly admitted it had actively sought to induce other regional hospital authorities to

²⁶ TNA, Lunacy Commission and BoC, MH/240-241, Circulars of the BoC, 1921-40, O.E. Dickinson (Secretary, BoC) to visiting committees of English and Welsh asylums (5 October 1923), ref 625.

²⁷ Wellcome Library, ‘The Board of Control and the Mental Health Services “Seen from the Centre”’, unpublished MS, 7913/19, p. 18.

²⁸ Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London and New York: Leicester University Press, 1999), p. 197; Cherry, *Mental Health Care in Modern England*, pp. 173, 245.

add admission hospitals and convalescent villas and noted its 'regret' that some still lacked this accommodation. Such comments attest to the Board's formal powerlessness and reliance on informal tactics of persuasion.²⁹ At the same time, however, other sources suggest that while gradual, the Board did succeed in encouraging the adoption of separate admission and convalescent units. An internal Ministry of Health memorandum, sent in 1936, affirmed that these buildings 'by no means uncommonly owe their origin to pressure by the Board of Control over a long period of years and... it is the duty of the Board of Control to exercise that pressure'.³⁰ The scheme for admission, convalescent, and staff blocks announced at Newcastle Borough Mental Hospital in 1938 exemplified the Board's persistence, as well as the success of its persuasive tactics. In 1935, the BoC's inspectors had robustly criticised the hospital's arrangements for new admissions.³¹ Newcastle City Council's chairman later acknowledged the influence the BoC's 'press[ure]... to bring... accommodation up to present day requirements when he unveiled plans for the new blocks in 1938.³²

At Newcastle and other asylums the onset of war delayed the completion of new admission and convalescent units; elsewhere, as Cherry's case study has identified, economic factors and local obstructionism may have impeded their spread even before 1939.³³ BoC inspectors repeatedly

²⁹ BoC, *Annual Report*, 1930, pp. 11, 151.

³⁰ TNA, Lunacy Commission and BoC, MH/67/187, Lancashire Mental Hospitals Board, Winwick Mental Hospital, Proposed Purchase of Land Adjoining the Winwick Mental Hospital Estate and Erection of an Admission Hospital', 1931-40, internal Ministry of Health Memorandum to Mr Neville, 19 December 1936, p. 1.

³¹ BoC, *Annual Report*, 1935, Newcastle City Mental Hospital, visited 25 September 1935, pp. 427-8.

³² 'Newcastle Mental Hospital: £180,000 Extensions', *Mental Health and Institutional Workers' Journal* 27:2 (February 1938), p. 12.

³³ Cherry, *Mental Health Care in Modern England*, p. 271.

requested Norfolk and Buckinghamshire to add convalescent villas and reception hospitals in the 1920 and 1930s, yet neither county formally submitted plans for these until the mid-1950s.³⁴ In at least some areas, therefore, a tension is perceptible between local authority inaction and the BoC's reformist ambitions. It was local authorities such as Buckinghamshire that ultimately decided whether to adopt, defer or decline plans for asylum remodelling. Obstacles to the BoC's reforms came from other central government departments, as well as from the county and borough councils. The Ministry of Health (MoH) applied pressure on departments to curtail spending in the 1920s, to meet stringent post-war economies, latterly enshrined in the Committee on National Expenditure's 'Geddes Axe' of 1921, which proposed swingeing cuts to public spending. Economic conditions and resultant budgetary constraints therefore limited how far the Board could define its own policy on asylum reconstruction. Financial recession in the early 1930s further stymied the BoC's freedom to promote structural change. The MoH decided in 1932 against a similar moratorium on building work to that applied after 1918, which meant that the BoC could continue to promote changes to mental hospital ground-plans.³⁵ Even so, the MoH's endorsement of the Ray Report, which it presented to Parliament in November 1932, publicly criticised the BoC for demanding 'too elaborate and expensive a standard of construction for mental hospitals'. As such, the Ray Report

³⁴ Ibid., pp. 173, 206; Crammer, *Asylum History*, pp. 142-3; BoC, *Annual Report*, 1924, Buckinghamshire, visited 9 April 1924, p. 177; BoC, *Annual Report*, 1925, Buckinghamshire, visited 17 March 1925, p. 180; BoC, *Annual Report*, 1927, Buckinghamshire, visited 24 March 1927, p. 85; BoC, *Annual Report*, 1937, Buckinghamshire, visited 23 March 1937, p. 242; Norfolk Record Office [NRO], St Andrew's Hospital, *Annual Report*, visited 14 March 1928, p. 12; BoC, *Annual Report*, 1930, 17 September 1930, p. 239.

³⁵ BoC, *Annual Report*, 1932, p. 12.

redefined the agenda from one centred on qualitative material improvements to one centred on quantitative financial imperatives.³⁶

For all its reformist intent, therefore, the BoC after 1919 confronted central government prohibitions, and local government inertia, which, in order to promote changes to admission and convalescent accommodation, it had to manage through persuasion and justification. Between 1918 and 1923, the BoC's reports conformed closely with MoH's policy, and actively dissuaded or excused authorities from constructing admission hospitals.³⁷ In the early 1930s, however, the Board's reports communicated a more equivocal message. The Ray Report openly castigated the Board for its failure to regulate local expenditure and its encouragement of new works. Instead, the Report's authors recommended that the BoC should relax its standards, and refuse to endorse local authority plans that exceeded these more modest specifications.³⁸ In defence, the Board claimed some local authorities held unrealistically low expectations about the need for improvements, and afforded mental health an unduly low priority as an area for investment. At the same time, the Board portrayed itself as a guardian of parsimony, when it professed other authorities had defied its cautions over budgetary management. Thus, the BoC claimed it shared the Ray Commission's concern to 'secure economy', even whilst it also continued to press for a larger allocation of local budgets for mental health.³⁹ Constrained by the economic priorities of the MoH, the BoC reported over 1931 and 1932 that mental hospitals had been 'compelled' to cut expenditure and 'restricted' in

³⁶ *Report of the Committee on Local Expenditure (England and Wales)* (London: H.M. Stationary Office, 1932), pp. 90-1.

³⁷ BoC, *Annual Report*, 1920, p. 23, 25; BoC, *Annual Report*, 1922, p. 5.

³⁸ *Report of the Committee on Local Expenditure*, pp. 90-1, 147.

³⁹ *Ibid.*, p. 90; BoC, *Annual Report*, 1932, pp. 12-13.

their development of new facilities.⁴⁰ Already by 1933, however, the Board reported 'good progress' in the construction of admission hospitals.⁴¹ It seems, therefore, that while central government turned the question of mental hospital reconstruction primarily into an economic question, the Board continued to raise and promote reform throughout the interwar period.

Nevertheless, the emphasis placed by the MoH on cost efficiencies prompted the BoC to compromise on the design of convalescent villas and the speed with which it could legitimately expect their completion. In February 1933, Minister of Health E. Hilton Young had accepted the BoC's recommendation that existing hospital standards could be maintained, but made it clear the Board must concentrate on economy, pending a general review.⁴² The BoC's chief architect, John Kirkland, responded with a list of four cost-saving expedients in the spring. Three of these concerned a reduction in the size of new hospital buildings, whilst the fourth recommended the substitution of 'cottage residences' in the place of 'Convalescent Villas'. Minutes reveal little about what the last suggestion might have entailed, but it is clear that the Board accepted that this plan equated to a reduction in standards.⁴³ In 1924, the Board had proposed that ideally, convalescent villas should allow each patient a separate bedroom.⁴⁴ The mention made of 'dormitories' in the revised cottage residences discussed in 1933 indicates that the BoC had at least conceded a loss of patient privacy in the interest of external pressure for economy. It seems, therefore, that a central government preoccupation with the public finances

⁴⁰ BoC, *Annual Report*, 1931, p. 1; BoC, *Annual Report*, 1932, p. 1.

⁴¹ *Ibid.*, 1933, p. 3.

⁴² TNA, Lunacy Commission and BoC, Minutes, MH 50/53, 7 and 21 February 1933.

⁴³ *Ibid.*, 11 April 1933.

⁴⁴ *BoC Annual Report*, 1924, p. 15.

directly influenced the form of convalescent villas, in ways that sacrificed therapeutic principle to economic pragmatism. There is evidence that even before its change in policy, the Board had reluctantly accepted local authority requests at Wadsley (West Riding) and Nottingham to reduce the height of admission hospitals.⁴⁵ Shortly after the 1933 review, however, the Board appears to have more proactively recommended a reduction in the height of convalescent and admission blocks planned at Ewell.⁴⁶ It seems, therefore, that the timing of plans may have influenced the local form convalescent villas took.

Despite a combination of formal powers and informal persuasion tactics, the BoC had to operate within a variety of legal, official, and material constraints. These limited its ability to independently decide policy, and to some extent shaped the approach of the lunacy authorities to convalescence. As Mary Fisher has noted, systemic overcrowding continued to worsen in the interwar period.⁴⁷ This created a practical imperative for change, even if overcrowding itself did not necessarily imply further mental hospital construction. Indeed, some historians have claimed overcrowding was a contributory factor behind alternative interwar community-based approaches to mental health, particularly in countries such as Germany and Holland.⁴⁸ The Board remained committed to an institutional approach to

⁴⁵ Ibid., 27 February 1932. 28 July 1932; TNA, Lunacy Commission and BoC, Yorkshire (West Riding) Mental Hospitals Board, Wadsley Mental Hospital: Proposed Extensions and New Admission Hospital, 1930-33', P. Barter (Secretary, BoC) to Heseltine (MoH), 2 August 1932.

⁴⁶ London Metropolitan Archive [LMA], London County Council, Mental Hospitals Committee, LCC/MIN/696-701, Minutes of General Purposes Sub-Committee, 11 July 1933.

⁴⁷ Mary Fisher, "'Getting Out of the Asylum': Discharge and Decarceration Issues in Asylum History' (unpublished PhD thesis, University of East Anglia, 2003), p. 232.

⁴⁸ Michael Neve, 'A Commentary on the History of Social Psychiatry and Psychotherapy in Twentieth-Century Germany, Holland and Great Britain', *Medical History* **48** (October 2004), p. 411; Harry Oosterhuis, 'Between Institutional Psychiatry and Mental Health Care: Social

treatment, however, where the convalescent villa seems to have partly fulfilled a similar function as a means to create extra beds. Montagu Lomax's highly public representation of asylums as 'mental prisons' and 'houses of detention', and subsequent official inquiries into institutional conditions, reflected badly upon mental hospitals, and helped create a broader agenda for institutional reform. Both the Cobb Committee and Macmillan Commission welcomed the construction of convalescent villas, and thereby exerted external influence on the Board to oversee their universal adoption. Lomax himself told the Macmillan Commission that probationary wards for convalescents would 'enormously assist... recovery'. Consequently, Lomax indicated how convalescence might offer one remedy to the prison-like aspects of the asylum he had recently criticised. In contrast, official economies placed limits on the BoC's freedom to set policy on convalescence, as did lunacy legislation that defined where convalescent homes could be built, and who could enter them. In sum, the BoC could not entirely determine its own policy on convalescence, but partly had to respond to the demands and desires of other groups.

2.2. Official Interest in Asylum Convalescence, 1845–1913

In 1856, the Lunacy Commission's annual report proposed that asylums should build cottage-like buildings for the 'quiet, orderly, chronic, and convalescing' alike. Chris Philo has speculated that the failure to differentiate between patients betrayed Commissioners' disinterestedness in the

Psychiatry in the Netherlands, 1916-2000', *Medical History* **48** (October 2004), p. 414; Heinz-Peter Schmiedebach and Stefan Priebe, 'Social Psychiatry in Germany in the Twentieth Century: Ideals and Models', *Medical History* **48** (October 2004), p. 468.

relationship between the design of these buildings and their occupants' prognosis.⁴⁹ The Commissioners did, however, distinguish the particular advantages that 'liberty of action' and 'probationary' freedoms would promote in convalescents, particularly to their independence and self-confidence. An emphasis on the small scale of these blocks, in comparison with the 'large asylum', and their description as an 'intermediate place of residence', identified the particular situation of these buildings, and their convalescent inhabitants, at a midway point between institution and home.⁵⁰ This envisaged the asylum somewhere between an extension of the domestic sphere and an institutionally-based alternative to contemporary boarding-out schemes developed in this period, notably in Scotland.⁵¹ This emphasis on domestic scalability corresponds with Andrew Scull and Mathew Thomson's interpretation of the later post-1900 villa system as a mode of design at least partly intended to foster an 'illusion' of homeliness.⁵² It seems therefore that this projected image of detached asylum blocks as homely environments pre-dated the villa system Scull and Thomson describe. In both 1856 and 1898 the Lunacy Commission made the same connection between relatively 'simple' and small detached blocks and patients' own homes. At the same time, however, the Commissioners also provided other justifications for asylum cottages, whether as a cheap and sustainable solution to

⁴⁹ Chris Philo, "'Enough To Drive One Mad": the Organization of Space in 19th-Century Lunatic Asylums', in Jennifer Wolch and Michael Dear (eds), *The Power of Geography: How Territory Shapes Social Life* (Boston and London: Unwin Hyman, 1989), p. 279.

⁵⁰ *Annual Report of the Lunacy Commission for the Year 1856*, pp. 26-8.

⁵¹ Scotland, under the separate legislative provisions of the Lunacy (Scotland) Act, 1857, established a widely-utilised system of maintenance in the community. This provided a precedent, which some medical superintendents at English asylums suggested might be applied in England. See Mark Finnane, 'Asylums, Families and the State', *History Workshop Journal* **20** (Autumn 1985), p. 142; Tom Walmsley, 'Psychiatry in Scotland', in German E. Berrios and Hugh Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Gaskell, 1991), pp. 301-2.

⁵² Scull, *Decarceration*, pp. 112-3; Thomson, *Problem of Mental Deficiency*, p. 114.

overcrowding (1856), or as a means to better classify patients (1856 and 1898).⁵³ Other medical and economic reasons therefore potentially informed the Lunacy Commission's advocacy of these buildings, though significantly their specific use for convalescents only appears to have emerged as a secondary consideration.

The Lunacy Commission's annual reports on individual institutions only occasionally mentioned convalescent accommodation before 1913. Asylums were therefore given considerable freedom in how and where they chose to accommodate recovering patients. Indeed, superintendents such as John Bucknill at Devon experimented with detached blocks and seaside residences for convalescents in this period, which Chris Philo and John Pickstone have instanced as an example of experimentation in asylum design and practice.⁵⁴ Commissioners uncritically surveyed a variety of different types of convalescent accommodation, which encompassed centralised wards in the main building (Prestwich, 1886), adapted staff accommodation (Hayward's Heath, 1881; Horton, 1907), isolation hospitals (North Riding, 1899; Bexley, 1903), and offsite homes (Winson Green, 1902 and 1913).⁵⁵ Lancaster was comparatively unusual among public asylums in being asked to consider opening a seaside convalescent home in 1883. Again, however, the Commissioners' main concern appears to have been the relief of overcrowding, rather than the recuperation of patients or the form of

⁵³ Ibid., p. 26; Lunacy Commission *Annual Report*, 1898, p. 10.

⁵⁴ Chris Philo and John Pickstone, 'Unpromising Configurations: Towards Local Historical Geographies of Psychiatry', *Health and Place* 15 (September 2009), p. 900.

⁵⁵ Lunacy Commission *Annual Report*, 1881, Hayward's Heath, Brighton, visited 7 June 1881, p. 339; 1886 (Prestwich), p. 77; Lunacy Commission *Annual Report*, 1902, Winson Green, Birmingham, visited 12 December 1902, p. 384; Lunacy Commission *Annual Report*, 1906, Bexley, visited 7 November 1906, p. 328; Lunacy Commission *Annual Report*, 1907, Horton, visited 29 June 1907, p. 354.

the buildings they might occupy.⁵⁶ While the Commissioners sometimes stated a preference for a specific type of convalescent accommodation, as in this case, they rarely criticised or commented on alternative plans, as in this case when Lancaster proposed to convert a detached asylum workshop into an onsite convalescent ward for females.⁵⁷ Nor did the Lunacy Commission seek to rigidly impose classification upon these buildings. Commissioners in the 1880s continued to regard detached blocks as equally suitable for quiet and convalescent patients. In a further indication that the Lunacy Commission prior to 1914 paid little regard to the specific needs of convalescents, it approved several plans for blocks that combined these groups.⁵⁸

Apparently more important to the Lunacy Commission than medical classification, was its concern to provide for the socio-economic expectations of its convalescent private and middle-class patients. Musical and literary amusements were deemed particularly important features in private convalescent accommodation. At a ward for female convalescents of the 'better class' at North Riding in 1882, the commissioners felt the patients would benefit from books, bookshelves and a piano.⁵⁹ A scant supply of books in the convalescent ward at Ipswich Asylum was particularly condemned in 1899 on the grounds that 'many... are of the private class and fairly intelligent'.⁶⁰ The Lunacy Commission appear to have determined the suitability of ward furnishings based on patients' social background, and

⁵⁶ *Ibid.*, 1883, Lancaster, visited 16 August 1883, p. 216.

⁵⁷ *Ibid.*, 1892, p. 71.

⁵⁸ *Ibid.*, 1889, Brookwood (Surrey), visited 24 January 1889, p. 186; Lunacy Commission *Annual Report*, 1889, North Riding, visited 15 May 1889, p. 263; Lunacy Commission *Annual Report*, 1912/13 [on Nottingham], pp. 39-40.

⁵⁹ *Ibid.*, 1882, North Riding, visited 7 March 1882, p. 291.

⁶⁰ *Ibid.*, 1899, Ipswich City Asylum, visited 22 November 1899, p. 387.

corresponding expectations of their cultural preferences. Gendered as well as classist assumptions are evident in the comment of the visiting commissioners to Winson Green in 1889, who commented on a 'museum' and natural history display attached to its male convalescent ward. Their view that the collections of tools on show were 'calculated to interest working men' suggests they linked the observation of these objects with the economic potential, rather than the cultural betterment, of their viewers.⁶¹ The assumption that these objects had been purposefully arranged for a male and working-class audience suggests how gender and social background may have informed provision for convalescence. Class apparently influenced what provision the Lunacy Commission considered appropriate. Commissioners expected that independently-funded Bootham Park should open a country or seaside branch convalescent home because these could be found in 'most institutions of this class'.⁶² In contrast, commissioners seem to have held no such expectations of most pauper asylums, which with their tacit assent, often lacked dedicated provision for convalescence into the twentieth century.

2.3. The Convalescent Villa within Official Policy, 1913–39

Convalescent villas and their associated admission hospitals assumed an important place within official discourse on mental hospital modernisation between 1919 and 1939. Representatives of the BoC repeatedly described them as 'modern' additions and as benchmarks of progressive institutional

⁶¹ Ibid., 1889, Winson Green Asylum, visited 27 March 1889, p. 274.

⁶² Ibid., 1898, Bootham Park, York, visited 22 July 1898, p. 414.

planning.⁶³ By the mid-1920s, the Board had firmly committed itself to reforming mental hospital accommodation for those in the earliest and latest stages of institutional treatment. In its report for 1924, the BoC announced its intention to promote the completion of admission hospitals and ‘ancillary’ convalescent homes at every mental hospital in the country.⁶⁴ Initially permissive, the BoC would increasingly view convalescent villas as an essential component within the modern mental hospital. By 1930 the BoC considered that no hospital could be ‘regarded as complete’ without admission and convalescent units, which they went on to suggest would help remedy an ‘obsolescent’ design.⁶⁵ Such strongly normative language indicates how far the BoC had come to believe these additions might have a transformative effect on their parent institutions. Successive chairmen of the BoC put this reasoning before a public audience, in two articles published in *The Times*. For Frederick Willis (Chairman, 1921–25), writing in 1928, admission hospitals and convalescent villas had helped make asylums into ‘real hospitals’, with separate facilities for the most curable cases.⁶⁶ His successor, Lawrence Brock (Chairman, 1925–45), shared this view, seeing the addition of these units as symbols of a new era of mental health. Comparing their addition within mental hospitals, with the recent development of psychiatric clinics in the community, Brock, like Willis,

⁶³ BoC, *Annual Report*, 1922, pp. 5, 97; BoC, *Annual Report*, 1928, p. 8; BoC, *Annual Report*, p. 11; TNA, Lunacy Commission and BoC, circulars, Laurence G. Brock (Chairman, BoC) to mental hospital visiting committees, ‘Mental Hospital Accommodation’, May 1931, 761, pp. 3-4; Sir Lawrence Brock, ‘Mental Health’, *The Times* **47803** (Thursday 30 September 1937), p. 47, col. D; F.C. Webster, ‘Modern Trends in the Planning of Mental Hospitals and other Psychiatric Units in England’, *Journal of Mental Science* **44** (January 1948), p. 100.

⁶⁴ BoC, *Annual Report*, 1924, p. 15.

⁶⁵ BoC, *Annual Report*, 1930, p. 11.

⁶⁶ [Frederick Willis] ‘The Board of Control, A Seven Years’ Review, The Lunacy Law’ *The Times* (Wednesday 4 July 1928), **44936**, p. 17, col. G.

perceived these buildings as facilitating a change from custodial care, to medical treatment.⁶⁷

As Martin Daunton and Bernhard Rieger have argued, claims to modernity have historically permitted those that make them to stress either discontinuity or continuity. Of these, they have perceived a greater tendency amongst the British in the interwar period to emphasise the modern as part of an evolutionary development, in contrast with continental conceptions that they claim more typically highlighted disjuncture with the past.⁶⁸ The BoC's representation of the modern appears to some extent to embody both tendencies: whilst the BoC envisaged the admission hospital and convalescent villa as part of a decisive shift from the outmoded asylum to the modern mental hospital, they nevertheless acknowledged their antecedents. Thus, the BoC's annual report for 1924 recorded the emergence of these buildings out of the reception hospitals founded in Scotland and Lancashire and villas established in the LCC's asylums in the nineteenth century.⁶⁹ So too, the references frequently made to these units as a 'step' or 'help' to modernisation suggested more incremental notions of change, even as they posited them as a key aspect of institutional reform.⁷⁰ A stronger emphasis on the transformative effect of these units is discernable elsewhere, however, as when Commissioners suggested in 1932 they would 'entirely

⁶⁷ Brock, 'Mental Health', p. 47, col. D.

⁶⁸ Bernhard Rieger and Martin Daunton, 'Introduction', in Martin Daunton and Bernhard Rieger (ed), *Meanings of Modernity: Britain from the Late-Victorian Era to World War II* (Oxford and New York: Berg, 2001), pp. 6, 9-11.

⁶⁹ BoC, *Annual Report*, 1924, pp. 12-14.

⁷⁰ BoC, *Annual Report*, 1925, [West Park, visited 16 November 1925], p. 255; BoC, *Annual Report*, 1930, p. 11; BoC, *Annual Report*, 1931, p. 7.

alter' the function of Banstead Mental Hospital as a curative institution.⁷¹ The relative silence in these reports over the continued use of older asylum buildings more tacitly downplayed the place of the old within the 'modern' mental hospital, and thereby highlighted novelty.

Between 1923–30, and 1934–37, the BoC's visiting commissioners advised slightly over half of the English mental hospitals built before 1937 (48 out of 94) to relocate convalescent accommodation within their grounds.⁷² More than simply a response to perceived local defects, this amounted to a programme of national reform. The Board openly admitted in 1930 that it sought to induce local authorities to add this accommodation.⁷³ Admission hospitals and convalescent villas, the BoC claimed in 1928, formed part of a broader effort to 'modernize hospitals of the older type'.⁷⁴ Analysis of twelve years of the Board's reports indicates that it more frequently advised pre-1860 asylums to add units for convalescents than later institutions (Figure 2). 77 per cent of asylums opened before 1860 (27/35) were pressured to add separate convalescent homes compared with between 38-40 per cent in any twenty years between 1861 and 1920.⁷⁵ Recent hospitals (e.g., Bexley, Severalls, and Long Grove) and older asylums (e.g., Cornwall, Winson Green, and Colney Hatch) had already

⁷¹ LMA, LCC, Mental Hospitals Committee, Presented Papers, copy of BoC Commissioners' visitation report to Banstead [visited 29-30 June 1932], 19 July 1932.

⁷² 1923 was the year that the BoC – following the recommendations of the Cobb Committee – recommended the establishment of admission hospitals and convalescent homes as part of new building programmes. There are gaps in the BoC's collation of all institutional reports (which in other years were included in the annexe to their main report), between 1931–33 (inclusive), and 1938-9.

⁷³ BoC, *Annual Report*, 1930, p. 151.

⁷⁴ BoC, *Annual Report*, 1928, p. 8.

⁷⁵ This excludes others that were called upon to improve arrangements for recent or recoverable patients, or to add admission hospitals, each of which also potentially implicated convalescent patients.

established detached convalescent homes by the mid-1920s.⁷⁶ These institutions were not called upon to modernise their facilities, presumably as they already at least partly fulfilled the BoC's requirements. Other notable exemptions included Devon (1845) and Exeter (1889), which conjointly established an out-patients clinic for recent and recoverable cases in 1925.⁷⁷ Devon would later in 1934 open 'Spurfield', a home for convalescents in the neighbouring village, having already previously utilised the Mental After-Care Association's (MACA) voluntarily-managed cottage homes (see Chapter Three).⁷⁸ It appears, therefore, that the BoC primarily targeted older institutions, but exempted some where they had developed alternative arrangements for early and convalescent care. Nevertheless, the majority of older asylums, and a smaller yet still substantial proportion of more recent mental hospitals, faced calls for reform, specifically aimed at their convalescent inmates.

⁷⁶ Dates of opening: Cornwall (1818), Winson Green (1850), Colney Hatch (1851), Bexley (1898), Long Grove (1907), Severalls (1913).

⁷⁷ TNA, Lunacy Commission and BoC, Minutes, 6 May 1925, p. 73.

⁷⁸ [Dr. Richard Eager, Devon County Mental Hospital, 1925:] 'Mental Hospital Reports', *Journal of Mental Science* **73** (April 1927), p. 334; Richard Eager, *The Treatment of Mental Disorders (Ancient and Modern)* (Exeter: W.V. Cole, 1945), p. 45.

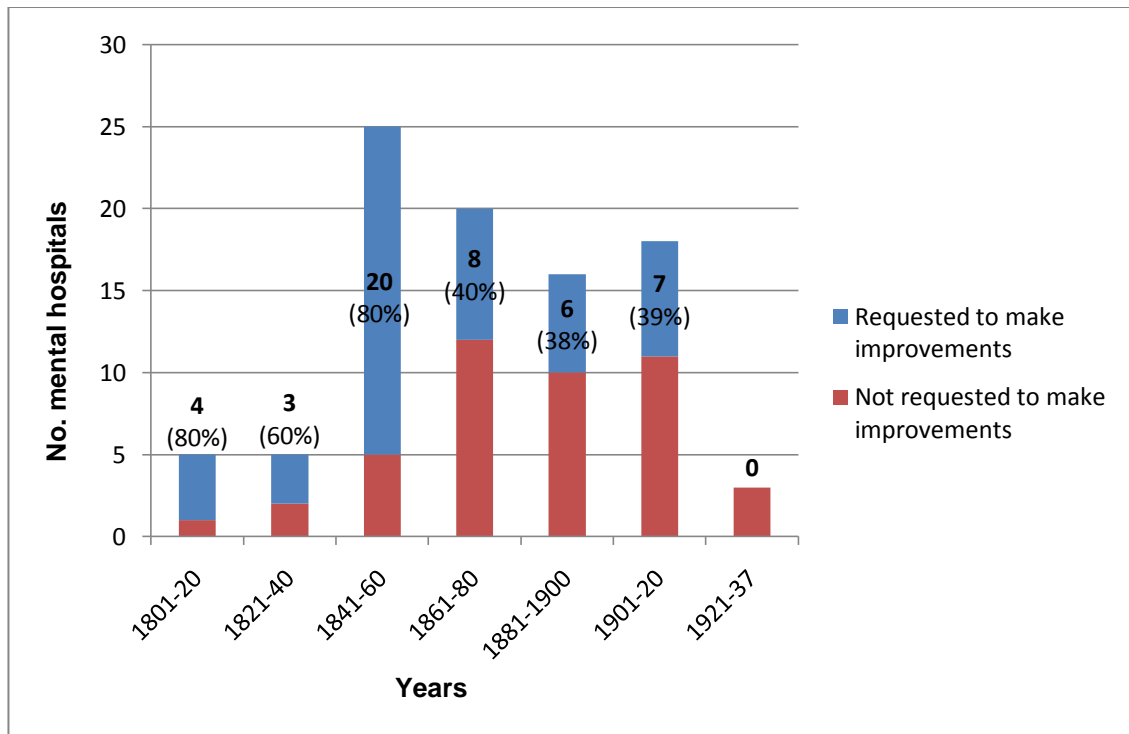


Figure 2: Age of Mental Hospital, and the Prevalence of Board of Control Appeals for Convalescent Villa Construction, 1923–30, 1934–37.

Source: Board of Control Annual Reports, 1919–30, 1934–37.

Mental hospitals planned in the immediate pre-war era such as Severalls (1913) and London’s post-Bexley asylums largely escaped comment from the BoC, which suggests the BoC regarded classification as broadly adequate.⁷⁹ It seems the BoC identified the roots of modern approaches to convalescence in pre-1914 planning, although they presented the idea that planning for recovery continued to advance. In 1924, the Board acknowledged T.E.K. Stansfield’s reorganisation of Bexley Asylum in the early 1900s, which included the use of paired buildings as an admission and

⁷⁹ The exception was Horton, which was recommended in 1936 to add a further convalescent villa for male patients. Existing villa accommodation for female cases, however, was not commented upon. Convalescent blocks at Severalls had been converted from TB wards, whilst those at Park Prewett were opened between 1924-5.

convalescent villas, as the 'prototype' for subsequent redevelopments.⁸⁰ In 1947/8, BoC architect F.C. Webster likewise over 1947/48 declared pre-1914 villas established at Bexley and Long Grove as the 'forerunner' of interwar early treatment centres. These comments suggest a view of pre-war units as developmental stages on the road to modern institutional planning, rather than its epitome. Despite recognising a family resemblance between pre- and post-war designs, Webster also explicitly identified early treatment centres with a post-1918 era of 'modern' institutional planning.⁸¹ Hubert Bond had been a medical officer at Bexley during its redevelopment under Stansfield and subsequently became Long Grove's first superintendent in 1907.⁸² Writing as a senior commissioner of the BoC in 1939, Bond reflected that the villas established at Long Grove represented a 'notable step forward'.⁸³ Bond and Webster therefore shared a view as members of the BoC themselves that paired admission hospitals and convalescent villas represented a central part of interwar mental hospital reform, even whilst both also recognised these stemmed from pre-war antecedents.

Although there were a few purpose-built mental hospitals after 1914, the majority of interwar mental hospitals had evolved over a longer period. These 'organic asylums' had subsequently added extensions not conceived at the time of their original construction, in ways that potentially changed the relationship between different patient classifications and the institutional

⁸⁰ BoC, *Annual Report*, 1924, pp. 13-14; T.E.K. Stansfield, 'The Villa or Colony System for the Care and Treatment of Cases of Mental Disease', *Journal of Mental Science* **61** (January 1914), pp. 31-2.

⁸¹ F.C. Webster, 'Modern Trends in the Planning of Modern Mental Hospitals and other Psychiatric Units in England', *Journal of Mental Science* **44** (January 1948), p. 100.

⁸² Tony Day, *More Like Home: The Story of Long Grove Hospital and How it was Closed to Improve Mental Health Services* (Hove: Pavilion, 1993), p. 5.

⁸³ Bond, 'Stansfield', pp. 1135-7.

environment.⁸⁴ Successive generations of asylum planners had left a legacy of wards, blocks and villas, based on the changing visions of institutional organisation explored in Chapter One. This had resulted in a variety of approaches to convalescence across English mental hospitals, which the Lunacy Commission had done little to correct before 1914. A survey made by the BoC in February 1925 (Figure 3) found that more than a third of institutions reserved no ward specifically for convalescents, whilst only a quarter contained the convalescent villas it desired, for at least one sex. Differences in the design, orientation, scale and internal management of such accommodation further added to this diversity, and are explored in the next section. Because only 3 per cent of England's interwar mental hospitals opened after 1925. Figure 2 suggests that the BoC placed most attention on the 76 per cent of asylums that pre-dated the first convalescent villas at Bexley, which formed the oldest institutions and the most likely to make what the Board in the 1920s and 1930s regarded as inadequate provision for recoverable patients.⁸⁵

⁸⁴ Susan Piddock, *A Space of their Own*, p. viii.

⁸⁵ Sixty-eight out of ninety asylums were built before 1898, when Bexley opened. Those county and borough mental hospitals opened after West Park in 1924 were Shenley (Middlesex: 1934), Runwell (East Ham and Southend: 1937); Barrow Gurney (Bristol: 1939);

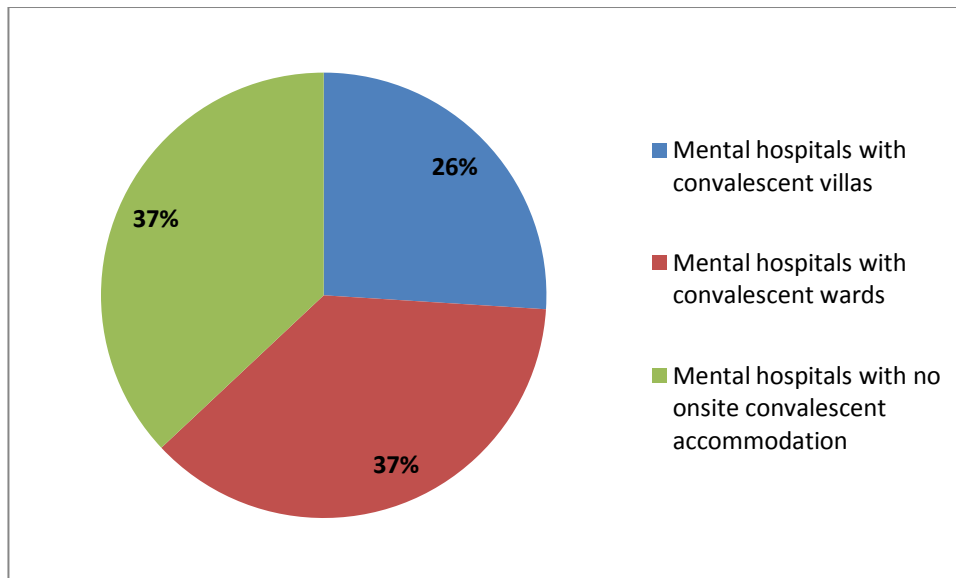


Figure 3: Convalescent Accommodation across English and Welsh Mental Hospitals, circa February 1925.

Source: Board of Control Annual Report, 1924, p. 15.

It is perhaps significant that the MoH kept a file entitled ‘Hospitalisation of Asylums’, which it opened upon the formation of the Cobb Committee set up to investigate Lomax’s claims.⁸⁶ The name given to this file encapsulates the MoH and BoC’s concern to improve the therapeutic credentials of the asylum. Montagu Lomax, whose criticisms and demands for reform in *Experiences of an Asylum Doctor* (1921) led to the Committee’s formation, had called for the gradual conversion of ‘huge barrack-like asylums’ that massed patients under one roof, to a more humane and homely “villa” or “cottage” system’. Lomax recognised the impossibility of wholesale reconstruction in the straitened economic climate of post-war Britain. Consequently, his plans for the ideal mental hospital envisaged a long-term

⁸⁶ TNA, Ministry of Health [MoH], MH 58/79 ‘Hospitalisation of Asylums’, 1922-3.

process of amelioration rather than rapid reform.⁸⁷ To claim it had affected short- to medium-term reforms, the BoC had little option but to recommend changes to existing institutions. In 1923, the BoC's secretary 'tentatively' proposed to Lawrence Brock (then Secretary, MoH, 1919–25) that a few authorities might be encouraged to construct mental hospitals. Even so, Barter also advised Brock that the BoC preferred 'to encourage the proper extension of existing institutions rather than the building of any large number of mental hospitals'.⁸⁸ Convalescent villas fitted this policy and allowed the relatively rapid remediation of asylums as incremental additions more cheaply and quickly than the construction or reconstruction of entirely new institutions.

One of the principle problems with the addition of supplementary villas was that they added to the scale of already sizeable institutions. A concern for the numbers in British asylums led the Cobb Committee to propose a limit of 1,000 patients.⁸⁹ The MoH agreed and informed the BoC of its reluctance to approve any additional buildings at larger asylums.⁹⁰ Consequently, the proposed maximum significantly compromised any attempt to approach reform through increased ward accommodation. In contrast, the BoC initially protested during 1922–23 that hospitals could efficiently manage 2,000 inmates, and in July 1923 announced its preference for the 'proper extension

⁸⁷ Lomax, *Experiences*, p. 38.

⁸⁸ Barter's proposal for the collaboration of East Ham and Southend-on-Sea was eventually realised in practice, with the opening of a mental hospital between these authorities in 1937. TNA, Lunacy Commission and Board of Control, 'London County, 11th London Mental Hosp[ita]l, West Park, Epsom Common', P. B[arter] (Secretary, BoC), to [Laurence] Brock (Assistant Secretary, MoH), 27 July 1923, p. 1.

⁸⁹ HMSO, *Report of the Committee on the Administration of Public Mental Hospitals* [Cmnd 1730] (London, 1923), p. 118.

⁹⁰ TNA, Lunacy Commission and BoC, 'West Park', 'W.A.R.' Minute, 20 November 1923.

of existing institutions'.⁹¹ Whereas the BoC's figure allowed for extensions, the Cobb Committee and MoH's calculations implied that for many authorities further construction would necessitate entirely new institutions. By 1923, thirty-five (38.9 per cent) of England's ninety asylums already exceeded 1,000 patients; by 1930 this number would rise to forty-six (51.1 per cent).⁹² After an interdepartmental meeting with the MoH in November 1923, the BoC agreed to publicly endorse the Cobb Committee's cap on institutional intake.⁹³ Nevertheless, in practice the Board continued to promote some of the biggest institutions to further increase their accommodation. Twelve of the twenty largest hospitals in 1930 received a request at some point over the interwar period from the BoC's visiting commissioners to add further accommodation for recoverable patients.⁹⁴ Despite its promise to adhere to a maximum of 1,000 patients, the BoC continued to press for additional extensions. In 1931, Lawrence Brock (Chairman, BoC) wrote to all mental hospital authorities that the Board would approve admission hospitals and convalescent villas 'without regard to the size of the hospital, since these are necessities of modern treatment'.⁹⁵

T.W. Harding has suggested the MoH used the Lomax affair and Cobb Committee debates to wrest the initiative from the BoC and initiate its own modernising agenda.⁹⁶ Harding's distinction between a reformist MoH,

⁹¹ *Ibid.*, "P.B." [P. Barter] to Brock, 27 July 1923, p. 1; BoC, *Annual Report*, 1922, p. 4.

⁹² BoC, *Annual Report*, 1923; BoC, *Annual Report*, 1930.

⁹³ TNA, Lunacy Commission and BoC, 'West Park', W.A.R. Minute [following meeting between Willis, Bond, and Brock on 19 November 1923], 20 November 1923.

⁹⁴ Six of these held in excess of 2,000 patients at this date. These were Prestwich (2,751), Lancaster (2,607), Long Grove (2,240), Wakefield (2,202), Rainhill (2,137), Horton (2,100), Napsbury (2,067).

⁹⁵ TNA, Lunacy Commission and Board of Control, Circulars, Laurence G. Brock, 'Mental Hospital Accommodation', 761, May 1931, p. 4.

⁹⁶ Harding, 'Powder and Shot', pp. 184-7.

and an obstructionist BoC, however, perhaps overlooks the extent to which the latter promoted its own vision of change. In the face of the MoH's preferred policy for new mental hospitals and objection to institutional expansion beyond 1,000 beds, it is particularly notable that the BoC successfully defended plans at larger hospitals for admission and convalescent units. Although Napsbury (2,067 beds) and Wadsley (1,817 beds) were among the twenty largest mental hospitals in England in 1930, the Board petitioned the MoH to allow the construction of convalescent villas at both asylums. In 1923, the Board had proactively encouraged the MoH to refuse Middlesex's plans to enlarge Napsbury from 1,750 to 2,500 beds, because it considered it 'undesirable to allow such a large number... at one institution'.⁹⁷ Whilst this conformed to the MoH's own preference for smaller asylums, the BoC's commissioners went on in 1930 to press for two small convalescent villas.⁹⁸ The Board therefore promoted a policy of selective reform, targeted primarily at the most recoverable. Even though the MoH took a sceptical view of plans for 140 extra beds at Wadsley, it eventually concluded 'we must agree to it'.⁹⁹ This compromise evidently conformed more closely to the BoC's plans for reform. While the BoC accepted the MoH's decision to reject further villas for semi-convalescent patients on account of Wadsley's size, the Board firmly endorsed the decision to build convalescent villas, which it argued were vital 'for classification and treatment on modern lines', regardless of institutional size.¹⁰⁰

⁹⁷ TNA, Lunacy Commission and BoC, 'London County, 11th London Mental Hosp[ita]l, West Park, Epsom Common', A. Wilkinson (Secretary, BoC) to MoH Secretary, 8 June 1923.

⁹⁸ BoC, *Annual Report*, 1930, Napsbury, visited 23 October 1930, p. 236.

⁹⁹ *Ibid.*, North (MoH) to Heseltine (MoH), 11 December 1930.

¹⁰⁰ TNA, Lunacy Commission and BoC, 'Wadsley: Proposed Extensions', P. Barter (Secretary, BoC) to Heseltine (MoH), 6 January 1931, pp. 1-2.

A policy of selective extension allowed the BoC to suggest that even the oldest and largest asylums could, over a relatively short period, take their place among the most progressive mental hospitals in the country. These additions were less ambitious than alternatives such as the Maudsley Hospital and clinic-based services, both of which the MoH documented in its file on the 'Hospitalisation of Asylums'.¹⁰¹ While Lomax called for the gradual extension of the villa principle to all hospitalised patients, and the MoH promoted entirely new institutions, the BoC more modestly prioritised improvements to existing asylums that would principally benefit a minority of recoverable patients. Rather than entirely demolish the most outdated institutions, as the Maudsley's superintendent Edward Mapother proposed to the Macmillan Commission in 1925, the BoC instead proposed a less drastic programme aimed at their remediation.¹⁰² As a caveat to this, it is important to note that the BoC in 1923 wrote to the MoH that it 'tentatively' endorsed the construction of mental hospitals in certain areas.¹⁰³ This was borne out in subsequent years, when the BoC pressed several authorities to contemplate additional institutions. Nevertheless, it typically justified these as a resolution to chronic overcrowding and in a number of cases, such as Lincolnshire, Lancashire and Portsmouth, continued to encourage the simultaneous addition of convalescent villas and admission hospitals.¹⁰⁴ The focus of the

¹⁰¹ TNA, MoH, 'Hospitalisation of Asylums'.

¹⁰² *Minutes of the Macmillan Commission*, Edward Mapother, interviewed 22 June 1925, p. 823.

¹⁰³ Of the BoC's recommendations for new hospitals, only P. Barter's proposed collaboration between East Ham and Southend-on-Sea resulted in a new mental hospital before World War Two, with the completion of Runwell in 1937. See TNA, Lunacy Commission and BoC, 'West Park', P. B[arter] (Secretary, BoC), to [Laurence] Brock (Assistant Secretary, MoH), 27 July 1923, p. 1.

¹⁰⁴ Those authorities the BoC called upon to erect new hospitals between 1919–39 included Lancashire, Kent, Essex, Middlesex, Northampton, Staffordshire, Surrey, West Riding, Birmingham, and a number of other city and borough authorities. See TNA, Lunacy

BoC's policy was instead on the short-term improvement of all English asylums, specifically targeted at those considered potentially most curable.

The BoC's rhetoric repeatedly juxtaposed those 'new' mental hospitals that featured separate admission hospitals and convalescent villas with 'old' unimproved asylums. Thus, in the 1930s visiting commissioners at Gloucester considered its admission wards 'out of date', and conversely argued at Cumberland that the addition of detached admission and convalescent blocks would bring the institution 'up-to-date'.¹⁰⁵ So too, P. Barter (Secretary, BoC) would claim in 1931 that the addition at Wadsley (1872) of convalescent villas, an admission hospital, and a nurses' home, would bring classification and treatment here up to 'modern' standards.¹⁰⁶ In this way, the BoC encouraged the majority of such older asylums to concentrate on remediable patients, so that they could claim parity with a handful of more recent institutions. Even the relatively new mental hospitals such as Winwick (1902) were represented as outmoded for its 'inadequate' convalescent wards and 'very unsatisfactory' admission wards. On the need for convalescent villas at Winwick, Barter claimed that 'without these units [i]nstitutions cannot be regarded as completely equipped with what are now

Commission and Board of Control, 'West Park', Barter to Brock, 27 July 1923, p. 2; 'Surrey County Council: Mental to Cost £60,000', *Mental Health and Institutional Workers' Journal* 25:6 (June 1936), p. 3; Bracebridge: Limit Fixed by Board of Control', *Mental Health and Institutional Workers' Journal* 25:6 (June 1936), p. 27 'Mental Hospitals: A Survey by the Chairman of the Board of Control', *Lancet* (18 July 1936), p. 149; 'New Mental Hospital for West Riding', *Mental Health and Institutional Workers' Journal* 26:1 (January 1937), p. 7; 'New Mental Hospital Suggested for Portsmouth: Old Buildings Alleged Obsolete', *Mental Health and Institutional Workers' Journal* 27: 3 (March 1938), p. 6.

¹⁰⁵ BoC, *Annual Report*, 1937, Gloucester, visited 2 January 1937, pp. 283-4; BoC, *Annual Report*, 1930, Cumberland, visited 6 February 1930, pp. 170-1.

¹⁰⁶ TNA, Lunacy Commission and BoC, 'Wadsley', P. Barter (Secretary, BoC) to Heseltine (MoH), 6 January 1931.

considered essential facilities for treatment'.¹⁰⁷ Consequently, the BoC represented convalescent villas as an integral and pivotal element in the modern mental hospital. As Vicky Long in particular has noted, this left much of the asylum superstructure untouched, and did little to remedy the stigma attached to those consigned to older wards.¹⁰⁸ Instead, a focus on improved facilities for recently-admitted and convalescent patients distracted attention away from the chronic and acute in centralised wards, and onto those the mental hospital might claim to have helped recover.

While the BoC presented convalescent villas as part of an overtly 'modern' and reformed approach to mental treatment, it also encouraged local authorities to complete these buildings on the more pragmatic grounds that they helped relieve institutional overcrowding. Its annual report for 1930 encouraged their completion to remedy short-term issues with the 'dangerously small' margin of beds available across all institutions; a point it repeatedly re-emphasised in its annual asylum inspections.¹⁰⁹

Commissioners appealed for admission hospitals and convalescent villas at Berry Wood (1930) and Barnsley Hall (1935) on the basis that these institutions needed further beds.¹¹⁰ Such explanations suggested that beyond their benefit to recoverable patients, the Board also attempted to encourage local authorities to consider convalescent villas part of a management strategy for the institution itself. At Derby, inspectors in 1936

¹⁰⁷ TNA, Lunacy Commission and Board of Control, 'Lancashire Mental Hospital Board – Winwick Mental Hospital: Proposed Purchase of Land Adjoining the Winwick Mental Hospital Estate and Erection of an Admission Hospital, 1931-40', P. Barter (Secretary, BoC) to Secretary of the Ministry of Health, 10 December 1931, p. 1.

¹⁰⁸ Long, 'Changing Public Representations of Mental Illness', p. 119.

¹⁰⁹ BoC, *Annual Report*, 1930, p. 9.

¹¹⁰ *Ibid.*, Berry Wood, visited 11 April 1930; BoC, *Annual Report*, 1935, Barnsley Hall, visited 7 November 1935, p. 377.

focused primarily on the impact that convalescent villas would have on institutional overcrowding, while those at Barming Heath felt they would 'do something to relieve' pressure on beds in the main hospital.¹¹¹ Two interwar BoC circulars on 'Mental Hospital Accommodation' would further frame these villas from the perspective of the extra beds they would provide, across all institutions.¹¹² Such evidence resonates with the view of historians who have speculated that initiatives to take patients outside the main asylum, and eventually into the community, may have been prompted by prosaic pressures on space, more than a concern for patients.¹¹³

It is possible, therefore, to perceive a range of therapeutic and managerial imperatives behind the BoC's advocacy of convalescent villas. From the perspective of institutional management and identity, they represented a relatively rapid and cheap solution to overcrowding, and contributed to a more positive public image of mental hospitals as socially-beneficial, curative establishments. Medically, the BoC emphasised their importance within a 'modern' system of classification. This drew upon similar ideas to those interwar asylum planners explored in Chapter One, who presented admission hospitals and convalescent villas as particularly beneficial for recent patients, who could pass through these units as a closed circuit that bypassed the asylum. As Mathew Thomson has perceived in the colony solution for mental defectives after 1913 these factors were often

¹¹¹ BoC, *Annual Report*, 1936, Derby County, visited 25 November 1936, pp. 234-5; BoC, *Annual Report*, 1937, Barming Heath, visited 21 April 1937, p. 298.

¹¹² TNA, Lunacy Commission and BoC, MH51/239-41, Board of Control Distributed Circulars', F.J. Willis (Chairman, BoC), 'Mental Hospital Accommodation'; Lawrence G. Brock, 'Mental Hospital Accommodation', May 1931, pp. 3-4.

¹¹³ Thomson, *Problem of Mental Deficiency*, pp. 114-5; Heinz-Peter Schmiedebach and Stefan Priebe, 'Social Psychiatry in Germany in the Twentieth Century: Ideas and Models', *Medical History* **48** (October 2004), p. 450.

interlinked in the BoC's reasoning.¹¹⁴ An example of this is Lawrence Brock's 1931 circular on 'Mental Hospital Accommodation', which combined therapeutic and administrative rationales for convalescent villa construction. Brock justified convalescent villas partly on the grounds that they promoted improved classification, and partly on the grounds they would provide a temporary antidote to overcrowding. Furthermore, Brock's equation between convalescent villas and 'modern' mental hospitals presented the former within a progressive rhetoric, which identified them as part of a break from an earlier generation of 'asylums'.¹¹⁵ In this way, convalescent villas can be seen as part of a modern approach to treatment, which allowed Brock, and superintendents, such as J.R. Lord, to claim elsewhere that it was public attitudes, rather than the 'asylum', which remained largely unenlightened. Thus, at the 1931 annual dinner of the Association of Mental Health Workers, Brock had argued that while the BoC might 'preach' and issue circulars, its main concern was to 'create a better instructed public opinion'.¹¹⁶

Over the 1920s, the BoC had committed itself to the construction of paired admission and convalescent units, based on arguments that these would mutually benefit patients and institutional management. With the passage of the Mental Treatment Act, 1930, the BoC introduced additional arguments on the specific benefit such units possessed for voluntary and temporary patients. It is at this stage that the Board appears to have become more insistent on their importance. In its 'Memorandum on the Mental

¹¹⁴ Thomson, *Problem of Mental Deficiency*, pp. 114.

¹¹⁵ TNA, Lunacy Commission and Board of Control, Circulars, Brock, 'Mental Hospital Accommodation', May 1931, p. 4.

¹¹⁶ [Brock, cited in] 'Mental Health Workers: An Appreciation', *Mental Health and Institutional Workers' Journal* 12:3 (15 July 1931), p. 65; Soanes, 'Reforming Asylums, Reforming Public Attitudes'.

Treatment Act', sent to mental hospitals in September 1930, the Board warned that there was an 'urgent need' for convalescent villas at all hospitals, to accommodate an anticipated influx of uncertified patients.¹¹⁷ This drew upon similar ideas to those interwar asylum planners explored in Chapter One, whose conception of admission hospitals and convalescent villas envisaged a closed circuit that would retain curable patients apart from the main asylum. Brock's memorandum of 1931 suggested that the Act had produced a legal and moral 'implied understanding' that uncertified patients would be treated separately from 'the main body of more or less chronic patients'.¹¹⁸ For all the rhetoric of modernity and therapeutic promise that the BoC attached to convalescent villas in the 1920s, Brock's statement suggests that he considered the vast majority of asylum inmates before the Act as unlikely to benefit from convalescence. Instead, his statement amounted to an acknowledgement that despite the attention the BoC paid to their therapeutic advantages, as reforms to the asylum, they had little significance to most patients. Nevertheless, it is also important to recognise a hope in Brock's circular, and the BoC's memorandum, that the Mental Treatment Act might genuinely usher in a new era of mental hospital treatment, which would offer recent admissions a better chance of ultimate recovery.

2.4. The Site and Design as Aspects of Recovery in the 'Modern' Halfway Home, 1919–39

¹¹⁷ TNA, Lunacy Commission and Board of Control, Circulars, 'Memorandum on the Mental Treatment Act, 1930', September 1930, pp. 1-2.

¹¹⁸ Ibid., Brock, 'Mental Hospital Accommodation', May 1931, p. 3.

The idea of convalescent accommodation as a 'halfway home' pervaded interwar discourse on villa construction, just as it had in the nineteenth century. Founder of the MACA, Henry Hawkins, and alienists John Bucknill and Daniel Hack Tuke, employed this phrase in the late 1870s to describe cottages used to board-out convalescents in the community.¹¹⁹ Onsite cottage homes had previously been represented as 'intermediate' places of residence in the Lunacy Commission's 1856 annual report, which again conveyed the position of convalescents between asylum and community. The idea was therefore an old one, when seventy years later, the BoC and Macmillan Commission chose to describe convalescent villas as a 'half-way home' (1924), and 'half-way house out' (1926).¹²⁰ Despite the BoC's representations of convalescent villas' modernity, these drew on longstanding ideas of convalescents' intermediacy between institutional wards and the private family home. Such descriptive continuity, however, potentially obscures more subtle changes in the relationship of these halfway homes, and the patients they were designed to house, with the asylum, its grounds, and the landscape and community beyond. Analysing the design, and situation of convalescent villas within the interwar mental hospital, offers a means of assessing the BoC's claims to novelty. The setting, scale and furnishing of these buildings reflected restrictions imposed by the availability of funds, suitable land, and the existing layout of buildings, as well as medical planning rationales. Yet they also suggest something of what

¹¹⁹ John Charles Bucknill and Daniel Hack Tuke, *Manual of Psychological Medicine* (London: J. & A Churchill, 1879, 4th edition), p. 683; Jennifer Smith, 'Forging the "Missing Link": The Significance of the Mental After Care Association Archive', *History of Psychiatry* 8 (1997), p. 408.

¹²⁰ *Report of the Royal Commission on Lunacy and Mental Disorder* (London: H.M. Stationary Office, 1926), p. 80; BoC, *Annual Report*, 1924, p. 15.

convalescence was intended to achieve as part of modern interwar mental hospital practice.

The Board's comments on the results of their 1925 survey showed that it was prepared to tolerate centralised convalescent wards, so long as classification was rigorously enforced, but ideally wanted villas introduced at all mental hospitals. Although the Board argued most central wards were too large and required their occupants to share ward gardens with other classes of patients, it also acknowledged that many operated with 'much success'.¹²¹ The BoC's visiting commissioner to Cheddleton, Staffordshire, in 1924 proved willing to consider the possibility of a separate ward garden for the exercise of patients in the existing convalescent ward. Again, their overriding motivation appears to have been to shield 'recoverable convalescents' from incurable chronic patients.¹²² The following year, however, visiting commissioners petitioned Cheddleton to establish an admission hospital and 'cottages', suggesting that where local classificatory issues remained unresolved, the Board maintained a preference for this standardised solution.¹²³ Shropshire, Norfolk and North Riding, moreover, were each requested to consider constructing admission hospitals, despite the pre-existence of convalescent villas.¹²⁴ It appears, therefore, that to be considered adequate, hospitals were expected to provide convalescent units set apart from those for recent admissions. Interestingly, the Board counted five units as 'convalescent homes' in its 1925 survey, despite observing that

¹²¹ BoC, *Annual Report*, 1924., p. 15.

¹²² Ibid., [Cheddleton, visited 28 June 1924,] p. 284.

¹²³ BoC, *Annual Report*, 1925, Cheddleton, Staffordshire, visited 30 April 1925, p. 291.

¹²⁴ BoC, *Annual Report*, 1937, North Riding, visited 24 March 1937, p. 428; BoC, *Annual Report*, 1930, Shropshire, visited 8 April 1930, p. 246; BoC, *Annual Report*, 1930, Norfolk, visited 17 September 1930, p. 239.

these were 'too large to be restricted to convalescents'.¹²⁵ A repeat BoC survey on detached admission and convalescent units, conducted in January 1932, however, applied stricter criteria. With the exception of villas that also contained 'a few working patients', respondents were instructed that 'a detached building is not to be classified as a Convalescent Villa merely because its inmates include convalescents'.¹²⁶

The idea of a 'halfway home' is evident in the BoC's concern to make clear the continued connectedness of admission and convalescent units to the community, despite their position within mental hospitals' grounds. Ideally, the BoC argued in 1933, admission hospitals should be 'well away from the main hospital', with dedicated access routes and distinctive names.¹²⁷ The admission hospital ('Wantage House') and convalescent villas ('Merchiston', 'The Rowans') at the registered hospital of St Andrew's, Northampton, were upheld by the BoC as models of their type. These met each of the Board's three criteria, combining geographical distance, seclusion, and their own descriptive identity.¹²⁸ Such units seem to have served a dual function, as Vicky Long has suggested, screening both recoverable patients, and the public, from an acquaintance with the main asylum.¹²⁹ Former Chairman of the BoC, Frederick Willis observed in *The Times* during 1928 that admission hospitals and convalescent villas enabled patients to 'pass... back to the community, recovered, without coming in

¹²⁵ Annual Report of the BoC, p. 15.

¹²⁶ TNA, Lunacy Commission and BoC, Circulars, questionnaire from P. Barter (Secretary, BoC), 'Detached Admission Hospitals', 766, January 1932.

¹²⁷ BoC, *Annual Report*, 1933, p. 3.

¹²⁸ *Ibid.*; Arthur Foss and Kerith Trick, *St Andrew's Hospital, Northampton: The First One Hundred and Fifty Years* (Cambridge: Granta Editions, 1989), p. 242.

¹²⁹ Long, 'Changing Public Representations of Mental Illness', p. 119.

contact with chronic cases'.¹³⁰ Willis here identified the protective function separate units provided recoverable cases, whilst also tacitly directing public attention particularly to the provision made for these patients. In a subsequent article written for *The Times* in 1937, Lawrence Brock would again conflate the modern English mental hospital, with admission and convalescent units 'in which improving cases can remain until recovery is complete'. Like Willis, Brock merely implied the survival of larger, older, buildings for longstanding cases, without exploring their place in what he constituted as a modern era of 'mental health'.¹³¹ As with the separate access roads the BoC argued should lead to these separate units, Willis and Brock's comments served to shield the public from the reality of buildings that housed those with little prospect of cure.

Offsite convalescent annexes offered the advantage of an even greater removal from central hospital buildings, although in contrast with private and registered asylums, relatively few public hospitals added these units. The annexes opened at Cornwall, Winson Green and Devon between 1927 and 1934 indicate the Board accepted plans for offsite branches, as the Lunacy Commission had done in the late nineteenth century.¹³² The BoC's inspectors in 1928 warmly appreciated the 'complete separation from institutional surroundings' they found at Bella Vista, Cornwall Mental Hospital's recently-opened male convalescent annexe at neighbouring Liskeard. Such homes functioned to further extend the distance between convalescents and the central asylum in ways openly recognised upon the

¹³⁰ [Willis] 'Board of Control, Seven Years' Review', p. 17, col. G.

¹³¹ Brock, 'Mental Health', p. 47, col. D.

¹³² Chris Philo, *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter, Ceredigion, and New York: Edwin Mellen Press, 2004), p. 650.

Board's visitation. Equally, inspectors referred benignly to the three-quarters of a mile that separated the female convalescent annexe (Lanival) from the hospital.¹³³ In line with changing voluntary and patient perceptions of convalescence, explored in Chapters Three and Four, the BoC in the 1930s also seems to have regarded offsite convalescent annexes as a form of holiday for patients. The BoC supported the MACA's development of coastal holiday homes for chronic mental hospital in-patients in this period for the comfort they offered residents.¹³⁴ As Chapter Four explores, patients themselves often regarded their stay as a form of holiday; a view the BoC seems to have shared in descriptions that presented convalescent annexes as a vacation from institutional life. When Middlesex submitted an informal proposal to the Board in 1938 to build a convalescent home at Milfield-on-Sea, the Board praised its 'desirability' on the comparable basis that it offered patients a 'holiday or change of environment'.¹³⁵

In the case of Middlesex, however, the Board felt unable to approve a proposal that 'appeared... to go beyond anything contemplated in the Lunacy and Mental Treatment Acts'.¹³⁶ Springfield already possessed an annexe at Malden for chronic cases, and in the inverse of the BoC's recommendations, before 1935 transferred those longstanding cases that recovered from this offsite home, into an onsite convalescent ward in the main asylum.¹³⁷ Springfield's superintendent Reginald Worth was also the Chairman of the MACA, which may explain Middlesex's particular interest in establishing a

¹³³ BoC, *Annual Report*, 1928, Cornwall, visited 19 December 1928

¹³⁴ Susannah Strong, *Community Care in the Making: A History of MACA 1879-2000* (London: MACA, 2000), p. 35; BoC, *Annual Report*, 1936, p. 9.

¹³⁵ TNA, Lunacy Commission and Board of Control, Minutes, 8 February 1938.

¹³⁶ *Ibid.*, 25 January 1938.

¹³⁷ Reginald Worth, 'Four Decades of Psychiatry', *Journal of Mental Science* **81** (October 1935), p. 764.

separate seaside convalescent home, comparable to those the Association itself ran. Springfield apparently already featured onsite villas for convalescents, and Shenley certainly did, although Middlesex's third hospital Napsbury, lacked comparable provision.¹³⁸ Ultimately, the BoC refused authorisation because it felt that the distance of the home from Springfield Hospital – which had been proposed as the home's parent institution – made it difficult to interpret the building as an 'annexe' within the letter of the law.¹³⁹ Generally supportive of offsite annexes, in this instance the BoC expressed its powerlessness to approve a home that was so spatially unconnected from any one mental hospital. Instead, the BoC's reports suggest it was satisfied that more modestly separated convalescent villas built within mental hospital grounds and cottage homes provided through the MACA would suffice. Local authorities were encouraged in the Board's *Memorandum on the Mental Treatment Act* in 1930 to ensure they had met the 'urgent' need for convalescent villas, which seems to have become its standard for reformed convalescent accommodation.

The Board appeared relatively content to leave the provision of offsite convalescent homes to the voluntary sector, and the MACA, rather than encouraging local authorities to construct their own. As Kathleen Jones has noted, the Board actively championed the MACA's activities, which included

¹³⁸ W.D. Nicol and E.L. Hutton referred to the transfer of a patient at Springfield in the 1920s to a 'convalescent villa', although it is unclear what this comprised. The BoC's visiting commissioners at Napsbury in 1930 commented on being 'struck... with the lack on each side of a villa of much smaller size (say 30 beds) to which would be sent only patients who have arrived at a convalescing stage of their illness'. W.D. Nicol and E.L. Hutton, 'Some Clinical Aspects of General Paralysis', *Journal of Mental Science* **81** (October 1935), p. 810; BoC, *Annual Report*, 1930, Napsbury, visited 23 October 1930, p. 236.

¹³⁹ *Ibid.*, 8 February 1938.

coordinating access to country and seaside homes.¹⁴⁰ In their report for 1933, the Board praised the 'great value' of the MACA's small homes for convalescing patients, and again publicised their value in a section on the Association's work in its 1937 report.¹⁴¹ Appreciative of the benefits offsite convalescent homes afforded rehabilitees in removing them from mental hospitals, the Board nevertheless identified them most strongly with the voluntary sector, whilst concentrating local authorities' attention on villas built within mental hospital grounds.

Instead, the Board focused on obstructing convalescents' sightlines to the main institution through strategic planting which helped create the *appearance* of remoteness and self-sufficiency, even where these buildings were relatively close. Whilst the BoC promoted convalescent units 'paired' with admission hospitals, they also stated they should be 'sufficiently distant' from one another to keep convalescents apart from recent patients with 'active mental symptoms'.¹⁴² As in the MACA's homes, recovery was presented as a collective and mutually-shared experience between convalescents, defined partly in opposition to the nearby admission hospital. Once improved, Lawrence Brock argued convalescents would 'benefit markedly by removal from daily contact with acute phases of mental illness [in admission hospitals,] and by living in association with other convalescent

¹⁴⁰ Kathleen Jones, *Mental Health and Social Policy, 1845-1959* (London: Routledge and Kegan Paul, 1960), p. 106; Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services* (London and Atlantic Highlands, NJ: Athlone, 1993), p. 128; E.g., BoC, *Annual Report*, 1924, p. 28; BoC, *Annual Report*, 1928, p.6; BoC, *Annual Report*, 1932, p. 44; BoC, *Annual Report*, 1933, p. 42.

¹⁴¹ BoC, *Annual Report*, 1933, p. 42; BoC, *Annual Report*, 1937, p. 37.

¹⁴² *Ibid.*, 1924, p. 15.

patients'.¹⁴³ In practice, the BoC approved a variety of solutions for enforcing this separation. Physical distance and the optical illusion of distance created by dividing and screening walls, trees and paths were all used in mental hospitals' plans to reinforce separation, and convalescents' perception of their separateness. Although relatively unusual as one of only four new mental hospitals built in England between 1919 and 1939, West Park (1924) exemplified the BoC's approach to institutional convalescence in this period. Whilst inspectors at the recently-opened West Park felt its admission hospital and convalescent units were 'somewhat near the main hospital', they also felt trees and shrubs would 'not be long in effectively screening them'.¹⁴⁴ Figure 4 illustrates how these units for recoverable patients occupied their own zone on the south side of West Park, separated by a walkway from the rest of the institution, and symbolically close to the community beyond.

¹⁴³ TNA, Lunacy Commission and Board of Control, 'Circulars', Brock, 'Mental Hospital Accommodation', p. 3.

¹⁴⁴ BoC, *Annual Report*, West Park, visited 16 November 1925, p. 256.

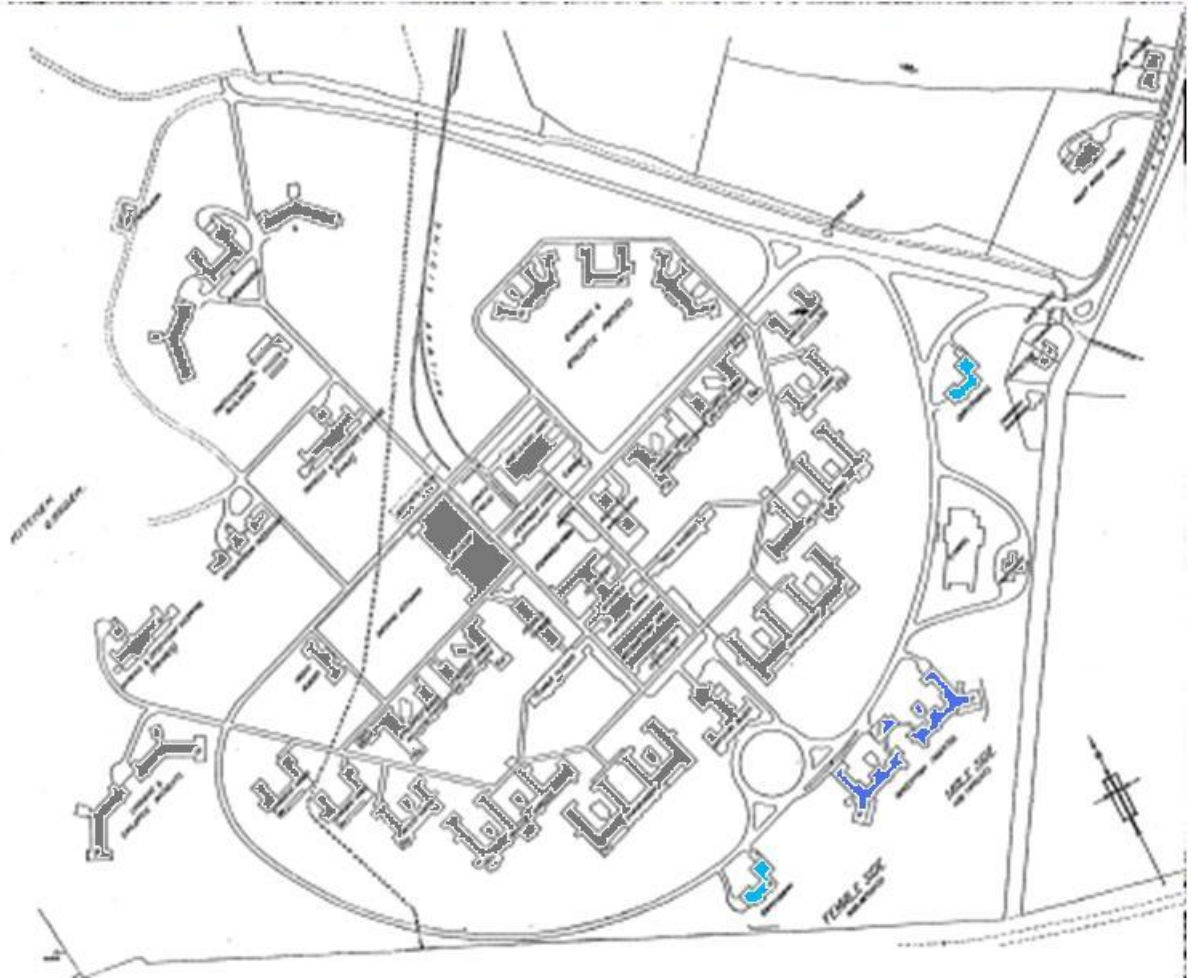


Figure 4: West Park Mental Hospital, Epsom (LCC), Process Print, 1926. The admission hospital is coloured dark blue; the convalescent villas that flank it are in light blue.

Source: WLHUM, Iconographic Collections

Privacy predominated over physical distance in planning at other institutions. The BoC's chief architect F.C. Webster would reflect in 1948 that the City of Bristol's new mental hospital at Barrow Gurney, opened in 1939, exemplified modern planning in part because its early treatment centre was 'secluded by woods' from the 'official block'.¹⁴⁵ This suggests seclusion and

¹⁴⁵ Webster, 'Modern Trends in Planning' p. 101.

the illusion of separation mattered more than the degree of distance placed between patients. Lawrence Brock prioritised this sense of invisibility between 'recoverable' patients, and other units, when he recommended in 1931 that admission and convalescent blocks 'should preferably be out of sight of the main buildings'.¹⁴⁶ Positioning convalescent villas beyond the view of the main hospital helped create an appearance of homeliness, meeting the Board's 1924 objective that they should seem 'home-like', and function as a 'half-way home'.¹⁴⁷

Access routes leading from convalescent villas tacitly defined their place in relation to both the mental hospital, and outlying community. Those built at the new hospitals of West Park and Shenley (Figures 4 and 7), and at the older asylum of Claybury, were each situated on the south side of the driveway into and out of the hospital grounds.¹⁴⁸ Driveways in each case bisected the hospital site, and thereby grouped convalescent villas and admission hospitals as part of the same sub-site, from the perspective of new patients and their visitors. Unable throughout the interwar period to arrange for entirely separate public convalescent homes for mental patients, the BoC instead appears to have settled upon increased separation for convalescents within the interwar mental hospital. The MoH in its 1938 report on mental hospital spending endorsed convalescent and admission units should represent a 'separate group of buildings'.¹⁴⁹ Like visible screens created through hedging, roads contributed to this sense of separateness,

¹⁴⁶ TNA, Lunacy Commission and Board of Control, 'Circulars', Brock, 'Mental Hospital Accommodation', p. 3.

¹⁴⁷ BoC, *Annual Report*, 1924, p. 15.

¹⁴⁸ Pryor, *Claybury*, pp. 80, 216.

¹⁴⁹ 'The Cost of Hospitals: Departmental Committee's Recommendations', *Mental Health and Institutional Workers' Journal* 27:6-7 (June-July 1938), p. 6.

and set convalescence at a further remove from the majority of mental hospital in-patients.

Inspectors to Shenley commented particularly on the grouping of the admission hospital with convalescent villas 'to the south of the main approach road', connecting these with 'adjoining' woods to the south, rather than the main building to the north of the drive.¹⁵⁰ Although the units at Rainhill were only partially divided from the main asylum by the newly-built access road, dedicated entrances underlined their distinctness to visitors who could reach them without passing through the main asylum. In each case, it was possible to drive directly to the admission hospital, passing through relatively few (if any) of the buildings used to accommodate acute or chronic cases. Separate entrances to the admission hospital and villas here and at Claybury and Winwick (Figures 5 and 8) went further in meeting the BoC's preferences.¹⁵¹ Patients and visitors who took these roads bypassed the main asylum and reinforced their sense of separation and difference from these buildings. When the BoC updated its *Suggestions and Instructions* for mental hospital design in 1940, it requested that grouped admission hospitals and convalescent villas should feature 'access either by an independent approach from the entrance to the estate or from a separate entrance from the public road'.¹⁵² This proved important for the BoC's claims that these units represented a break from the past, and created the sense that these represented a model mental hospital in miniature in their own right.

¹⁵⁰ BoC, *Annual Report*, 1934, Shenley, visited 17 and 19 December 1934, p. 270.

¹⁵¹ *Ibid.*, 1933, p. 21.

¹⁵² Devon Record Office, Exeter Mental Healthcare (c. 1920-1987), 6227/0-1, BoC, *Suggestions and Instructions for the Arrangement, Planning, and Construction of Mental Hospitals* (London: H.M. Stationary Office, 1941), p. 5.

Open spaces and strategically-located trees created a natural barrier and sense of distance devised to shield convalescents, yet the Board also seems to have considered them intrinsically beneficial to recovery. Inspectors variously highlighted the ‘very fine views’ (Shenley, 1934), ‘commanding views’ (Plymouth, 1937), and ‘beautiful’ situation (Cane Hill, 1936) seen from convalescent villas.¹⁵³ Visitors to Plymouth thought the villa ‘ideally situated’ due to its aspect across the surrounding countryside.¹⁵⁴ Such ideas were not new. Guidelines on asylum planning, issued by the Lunacy Commission in 1871, had emphasised the importance of choosing sites that optimised sun, fresh air, and an ‘uninterrupted view of the surrounding country’ for the ‘principle rooms’.¹⁵⁵ When G.T. Hine submitted plans for Claybury Asylum in 1887, he assured the commissioners that the ‘most important wards’ enjoyed precisely such an ‘uninterrupted view’.¹⁵⁶ His plan placed acute and infirm cases (a classification incorporating recent cases) in wards at southern frontage of the building, whilst chronic patients were hidden to the rear of the building (Figure 5).¹⁵⁷ Roy Porter has considered that back wards acted as a form of ‘excommunication’ designed to silence noisy patients, yet Hine appears more concerned with visual than aural motives, reserving the best south-facing views for the most curable

¹⁵³ BoC, *Annual Report*, 1934, Shenley, visited 17 and 19 December 1934, p. 270; BoC, *Annual Report*, 1936, Cane Hill, visited 24 June 1936, p. 296; BoC, *Annual Report*, 1937, Plymouth, visited 9 November 1937, p. 496.

¹⁵⁴ *Ibid.*, 1937, Plymouth, visited 9 November 1937, p. 496.

¹⁵⁵ Palmer Phillips, ‘Suggestions and Instructions’, p. 628.

¹⁵⁶ TNA, Lunacy Commission and Board of Control, ‘Claybury, 1887-8’, George T. Hine, ‘Report Accompanying Design for Proposed Fourth Lunatic Asylum for Middlesex’, 7 April 1887, p. 1.

¹⁵⁷ *Ibid.*, pp. 2-3; TNA, Lunacy Commission and Board of Control, ‘Claybury’, C.A. Howell, Lunacy Commission report on G.T. Hine’s plans for Claybury’, 20 June 1887, p. 2; Cochrane, ‘Humane, Economical, and Medically Wise’, p. 254; Andrew Scull, ‘A Convenient Place for Inconvenient People: The Victorian Lunatic Asylum’, in Anthony D. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London, Boston, and Henley, Oxon: Routledge and Kegan Paul, 1980), pp. 46-7.

patients.¹⁵⁸ Claybury's ward layout, on the basis of Hine's commentary, was primarily intended to privilege the recoverable, rather than deprive the disorderly. Inspectors' comments in the 1920 and 1930s suggest the panorama visible from convalescent villas remained a significant criterion on which the Board measured their suitability. Inspectors at Wakefield in 1934 would question whether Hatfield Hall, 'with its really beautiful garden and view', might not be more suitable for convalescents than the mental defectives then in residence.¹⁵⁹

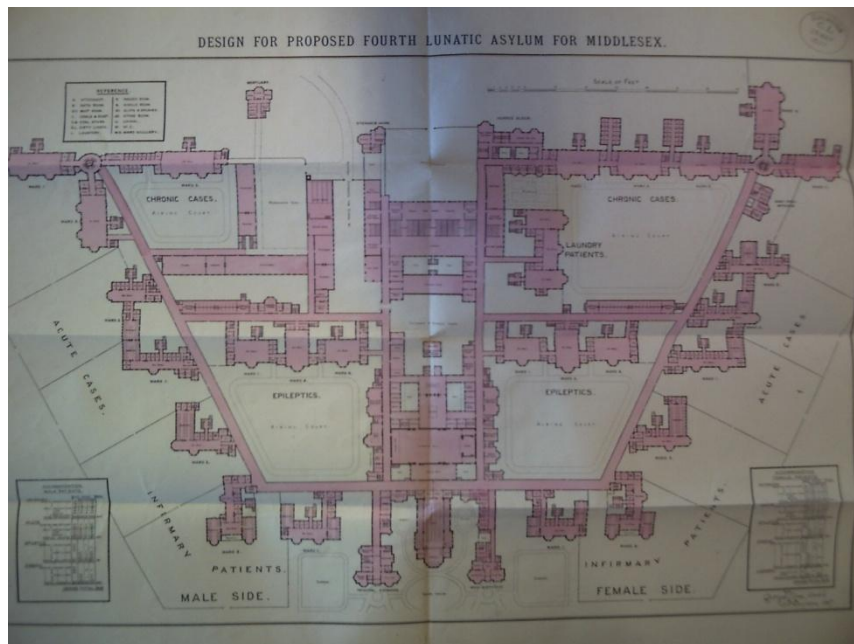


Figure 5: Plan of Proposed Middlesex Asylum [Claybury] by G.T. Hine, 1887.

Chronic patients are shown at the rear of the building (top).

Source: TNA, Lunacy Commission, MH 83/185, Claybury.

¹⁵⁸ Porter, *Madness*, p. 158.

¹⁵⁹ BoC, *Annual Report*, 1934, Wakefield, visited 18 August 1934, p. 331.



Figure 6: Proposed Site of Admission Hospital, Rainhill Mental Hospital, 25 January 1937. The convalescent villas are shown in hatching at the top and bottom right of the image (north and south-west, respectively).

Source: TNA, Lancashire Mental Hospital Board, MH 67/182, Rainhill Mental Hospital, Proposed Admission Hospital and Convalescent Homes.

A southerly location seems to have been considered less important than the view obtainable from villas across the surrounding landscape. The position of interwar convalescent villas within mental hospital sites varied considerably. While those at West Park and Rainhill occupied the southernmost part of the grounds, others at West Ham (c.1934) and Gateshead (1939) were located to the north of the main buildings. Convalescent blocks added to Bethlem's purpose-built new hospital at Beckenham in 1930, similarly occupied a northerly situation, which gave it a prospect southwards over an expanse of the asylum grounds that looked

towards stands of trees and Home Farm.¹⁶⁰ Whilst historians have observed that the rural location of nineteenth-century asylums was designed to provide the advantage of good views for all patients, it appears convalescents continued to be offered a particularly privileged position in this respect.¹⁶¹ Despite their close proximity to other buildings, patients in the south-east facing dormitories and dayrooms at Shenley's semi-convalescent villas faced away from other units of accommodation and towards the landscape beyond (Figure 7). The detached mansion set aside for those in a more advanced state of convalescence, while occupying a more central site flanked by blocks for intermediate, private, and quiet and harmless cases, enjoyed a similarly good vantage point. Dashed lines indicate local topography, and show the mansion occupying a prominence at the highest point in the site. Unlike the large 'closed' buildings and administrative blocks that shared this level, residents were afforded a largely unimpeded view to the south, with only the nurses' home and farm buildings below. As with Bethlem, open ground sloping downhill from the mansion to the south naturally channelled the view away from other buildings, and across woodland below. Inspectors' comments suggest the BoC particularly commended the scenic views obtainable from such convalescent units, and prioritised visual perspective over either the distance, or position, of these units in relation to other hospital buildings.

¹⁶⁰ 'The New Mental Hospital', *Journal of Mental Science* **77** (January 1931), p. 289.

¹⁶¹ Taylor, *Hospital and Asylum Architecture*, p. 149; Richardson, *English Hospitals*, p. 174.

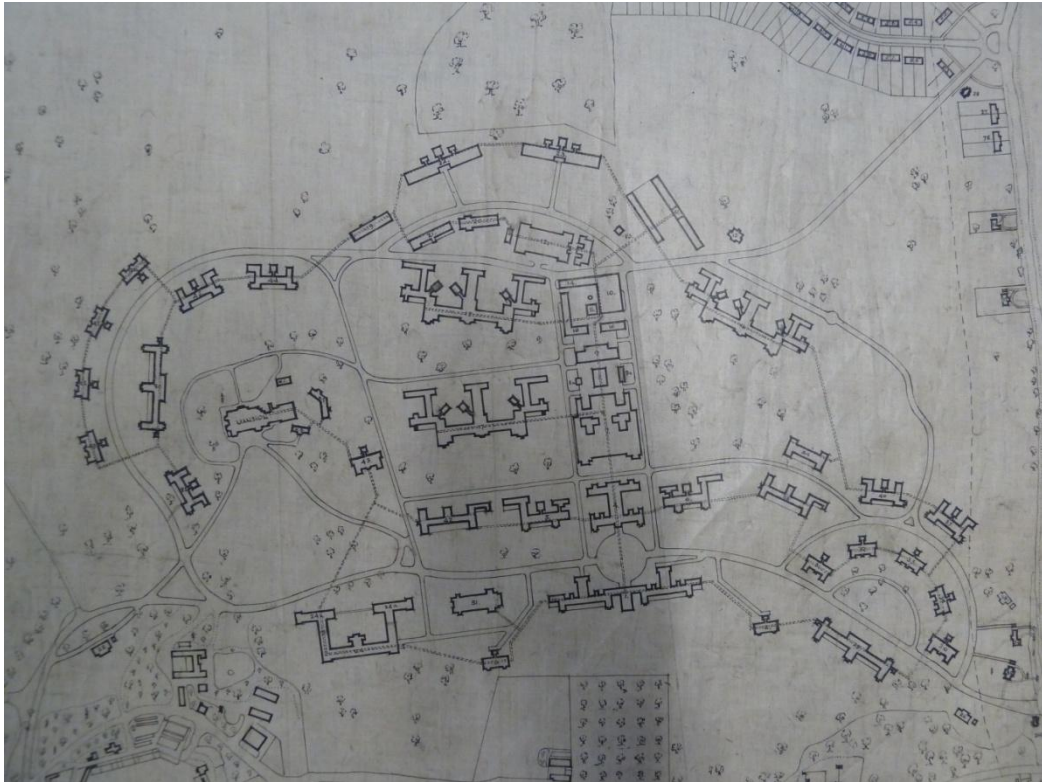


Figure 7: Plan of proposed Shenley Mental Hospital, 1934. The semi-convalescent villas are the two small buildings at the very bottom of the main cluster, set just in front of the broad admission hospital in the centre. The mansion converted for convalescents is the larger building on the left of the image, which shows it set on a hill and surrounded by trees that obscure it from other nearby villas.

Source: LMA, Shenley Mental Hospital, HH49/SHY/P/01, Plans.

Windows and doors in convalescent villas were intended to provide rehabilitees with more than a psychological attachment to the landscape. Inspectors at Littlemore, Oxford, in 1923 reported Dr Good's proposal to allow 'convalescents and other trustworthy patients free access to the grounds'. The Board warned in this instance, however, that it would prove 'difficult in the absence of detached villas'.¹⁶² Separate parole villas

¹⁶² BoC, *Annual Report*, 1923, Littlemore, visited 18 May 1923, p. 215.

established at the same time as convalescent villas (e.g., Sunderland, Derby) also provided other quiet and working 'parole' patients with a means of venturing into the landscape beyond.¹⁶³ Parole was also commended in the BoC's reports as an 'inducement to good behaviour', a benefit to 'happiness and contentment', and an encouragement for other patients to aspire to independence outside the hospital.¹⁶⁴ Imminence of discharge made convalescents particularly suitable for parole, which it was hoped would prepare them for life beyond institutional walls. Indeed, the BoC's 1924 guidance on convalescent villa construction focused solely on their practical use in bringing patients into direct contact with the outdoors, rather than the light or view they might provide. 'No windows should be stopped and all doors giving egress and ingress should remain unlocked during the day-time', the Board recommended, adding that such liberties helped make villas a 'half-way home'.¹⁶⁵ Considered closer to recovery than parole patients, rehabilitees' parole was seen as the next probationary stage before discharge. On proposing the establishment of small convalescent villas at

¹⁶³ George M. Robertson wrote in 1922 that villas that he had seen in Scottish asylums for convalescent patients, and quiet patients, had helped these selected patients 'lead almost an ordinary domestic life'. Liam Clarke has noted that thirteen English county borough asylums employed an open door system to some extent in 1891, although he has also argued that mental hospitals remained largely custodial in the interwar period. See George M. Robertson, 'The Hospitalisation of the Scottish Asylum System', *Journal of Mental Science* **68** (October 1922), p. 327; Liam Clarke, 'The Opening of Doors in British Mental Hospitals in the 1950s', *History of Psychiatry* **4** (December 1993), pp. 528, 530; TNA, Ministry of Health and Ministry of Labour, MH 61/35, 'County Borough of Sunderland: Extension to Mental Hospital, Ryhope', MacIntyre to C. Forbes Adam (Sunderland Borough Council), 23 December 1923; BoC, *Annual Report*, 1936, Derby County, visited 25 November 1936, pp. 234-5.

¹⁶⁴ BoC, *Annual Report*, 1923, pp. 9-10; BoC, *Annual Report*, 1924, p. 15; BoC, *Annual Report*, 1933, p. 8.

¹⁶⁵ *Ibid.*, 1924, p. 15.

Bristol in 1925, inspectors would again insist their value lay in assisting parole, which in turn ‘would instil a feeling of “halfway home”’.¹⁶⁶

The proximity of suitable places for convalescents to venture on parole followed this concern that these units should allow patients liberty of movement. Inspectors at Winwick accepted that an existing mansion might serve for female convalescents and other patients ‘trusted with limited parole’, adding that ‘if so used the hall and garden attached could be made a most comfortable residence’.¹⁶⁷ The gardens were therefore considered as an element of the building’s particular suitability for convalescents and other patients with outdoor privileges. Such concerns remained in the Board’s mind when Lancashire Mental Health Board (LAB) proposed to acquire a plot of farmland adjacent to Winwick in 1931, on the opposite side of a public road (Figure 8). P. Barter wrote to the MoH in December that the Board proposed to ask the LAB ‘to consider allocating sites for Convalescent Villas in addition to the Admission Hospital’.¹⁶⁸ When Hubert Bond visited the estate in 1935 and proposed the purchase of 35 acres of the adjoining Hulme Farm Estate for one of these villas, he again emphasised the advantages the additional space would offer its convalescent residents. Amongst other functions, Bond suggested the site would prove ‘very suitable’ for allowing patients lodged here ‘free parole of the land’.¹⁶⁹

¹⁶⁶ Ibid., 1925, Bristol, visited 1 October 1925, p. 334.

¹⁶⁷ Ibid., 1928, Winwick, visited 7 February 1928, p. 150

¹⁶⁸ TNA, Lunacy Commission and the Board of Control, ‘Winwick’, memorandum from P. Barter to Secretary of the MoH, 10 December 1931, p. 1.

¹⁶⁹ Ibid., extract of letter from BoC to Winwick, 30 July 1935, in case history of the Lancashire Mental Hospitals Board, 29 May 1936, pp. 1-2.

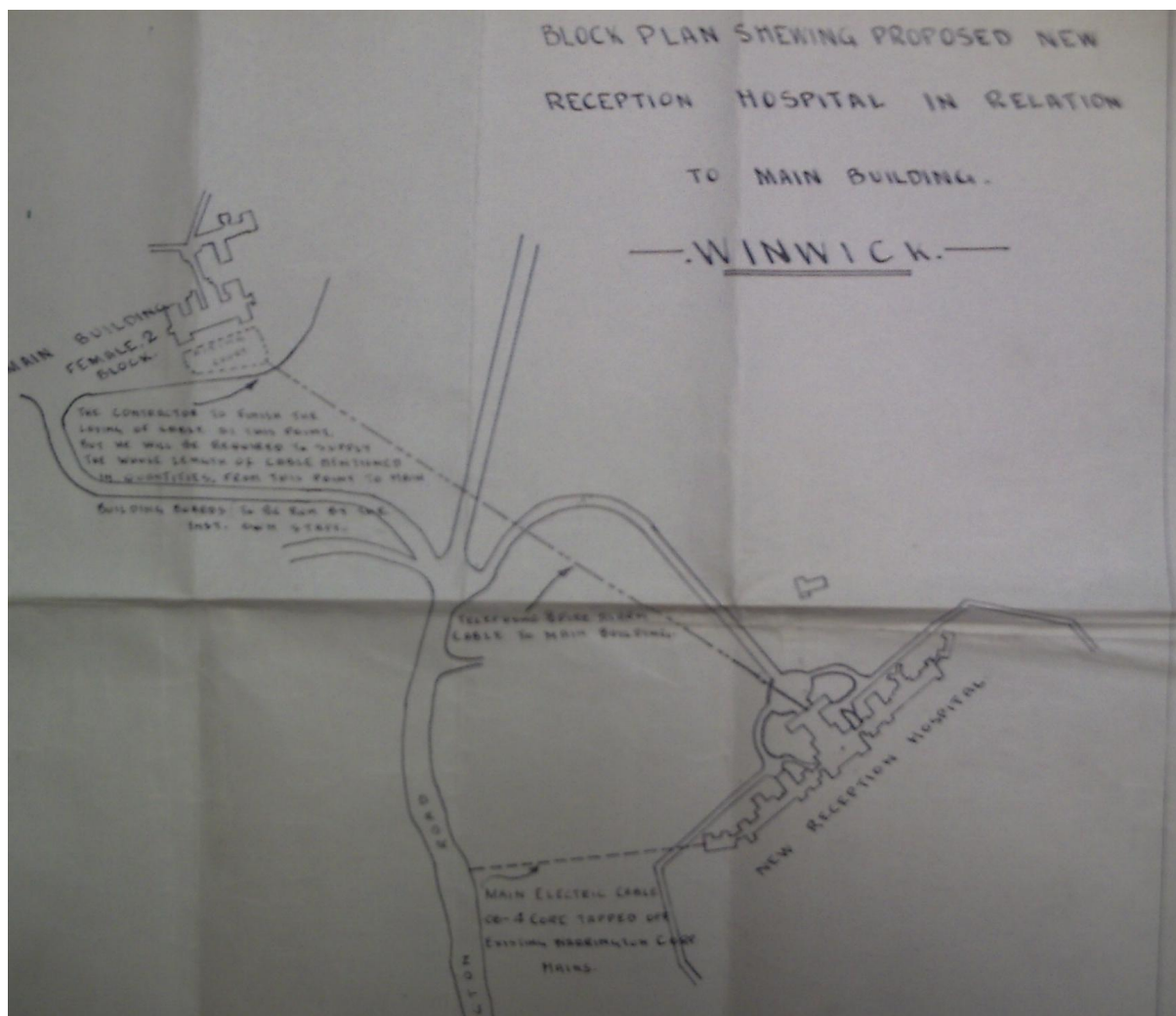


Figure 8: Plan of Proposed Reception Hospital, Winwick Mental Hospital, 1937.

Source: TNA, Lancashire Mental Hospitals Board, MH 67/187, Winwick Mental Hospital, Proposed Purchase of Land Adjoining the Winwick Mental Hospital Estate and Erection of an Admission Hospital.

BoC inspectors at Claybury's reception and convalescent villas and at one of Cornwall's convalescent homes particularly admitted their 'charming'

gardens.¹⁷⁰ These spaces formed a smaller, more dedicated area for convalescents to inhabit within close reach of the villas. The BoC's 1933 *Memorandum on Occupational Therapy* considered gardens beneficial for employing selected residents of admission and convalescent units; a connection between outdoors occupation and recovery that Clare Hickman has traced back to the early nineteenth century.¹⁷¹ At Cornwall, however, inspectors also identified the garden as a place of relaxation, observing the majority of patients here 'enjoying the sunshine'.¹⁷² By the mid-1930s, the BoC was recommending the improvement of all hospital ward gardens, yet as in other areas of its policy particularly focused on recoverable patients. In its annual report for 1934, the Board proposed hospitals replace iron fences with stiff hedges, in order to reduce both the 'challenge' of escape and feeling of captivity instilled in patients by railings. Admission hospitals, however, received special mention, with the Board considering it 'particularly important' to ensure their gardens were designed 'on more liberal lines'.¹⁷³ Convalescent villas built alongside the admission hospital were also considered to benefit from the addition of recreation facilities. Inspectors at Wadsley in 1937 felt bowling greens, lawns, and tennis courts would 'add to [patients]... already pleasing surroundings'.¹⁷⁴ Indicative of the greater

¹⁷⁰ BoC, *Annual Report*, 1928, Cornwall, visited 19 December 1928, p. 103; BoC, *Annual Report*, 1937, Claybury, visited 8 October 1937, p. 339.

¹⁷¹ TNA, Lunacy Commission and Board of Control, Circulars, *Memorandum on Occupational Therapy* (London: HM Stationary Office, 1933), p. 20; Hickman, 'Vix Medicatrix Naturae', p. 124.

¹⁷² BoC, *Annual Report*, 1937, Cornwall, visited 12 November 1937, p. 255.

¹⁷³ BoC, *Annual Report*, 1934, pp. 7-8.

¹⁷⁴ Such leisure facilities were also placed adjacent to convalescent villas planned at other mental hospitals in the interwar period such as Rainhill (Figure Three) and Shenley. At Stafford inspectors specifically commented on the 'good lawns' outside the convalescent villas and the bowling green outside its neighbouring admission hospital. See BoC, *Annual Report*, 1937, Wadsley visited 19 March 1937, p. 435; BoC, *Annual Report*, 1935, Stafford visited 26 June 1936, p. 346; TNA, Lancashire Mental Hospitals Board, MH 67/182, Rainhill

freedoms given to convalescents here, however, inspectors also praised the access these patients were given to football and cricket, through an arrangement with the Moseley Friends' Institute Athletics Club.¹⁷⁵ Parole meant convalescents in this case had access to facilities beyond their immediate environment, as well as in connection with those recreational amenities added in conjunction with the admission hospital.

Homeliness lay at the core of the BoC's ideal vision of convalescent villas. The Board argued in 1924 that onsite homes 'should be as home-like as possible', which it considered should be affected both through homes' small scale, internal room divisions, and attention to domestic details.¹⁷⁶ It sought the subdivision of larger homes into smaller 'cottages' of approximately twelve residents each, and, where single rooms were impractical, a maximum of four beds in each dormitory.¹⁷⁷ Small rooms in modern admission hospitals and villas, the Board noted in its report for 1938, offered a comparable degree of 'quietness and privacy' to the central library found in the main building of some mental hospitals.¹⁷⁸ The bookcases, sofas, and armchairs shown in the dayrooms of the male convalescent villa ('Willow') and Admission Hospital, both opened at Ewell in 1936 (Figures 9-10) suggest reading was positively encouraged in these units. The practice of reading itself offered a mental retreat into privacy, even while the reader may have shared the room with other recent or recoverable patients. While parole offered convalescents greater independence of movement outside

Mental Hospital and Convalescent Homes, 'Proposed Site of Mental Hospital', 25 January 1937.

¹⁷⁵ BoC, *Annual Report*, 1935, Winson Green, visited 13 August 1935, p. 397.

¹⁷⁶ *Ibid.*, p. 15.

¹⁷⁷ *Ibid.*

¹⁷⁸ *Ibid.*, 1939, p. 69.

their villas, the architecture, design, and furnishing of these villas reflected the Board's concern to provide rehabilitees with greater control over their own actions. Simple activities like making a cup of tea were felt suitable for convalescents to manage on their own, which led inspectors at Whittingham in 1925 and Nottingham in 1937 to recommend the introduction of smaller teapots. In the 1930s, inspectors would also comment favourably on the provision of patient lockers in convalescent villas.¹⁷⁹ These enhancements to patient independence and privacy, like parole, were not restricted to convalescents alone, yet became particularly associated in inspectors' reports with rehabilitees.¹⁸⁰



Figure 9: Interior of Day Room, Male Convalescent Villa ('Willow'), Ewell Mental Hospital, December 1936.

Source: LMA, General Subjects [Mental Hospital Photographs], SC/PHL/02/0584-81.

¹⁷⁹ BoC, *Annual Report*, 1925, Whittingham, visited 19 June 1925, p. 231; BoC, *Annual Report*, 1937, Nottingham, visited 5 February 1937, p. 377.

¹⁸⁰ *Ibid.*, 1935, North Riding, visited 11 January 1935, p. 388; *Ibid.*, 1930, Banstead, visited 4-5 March 1937, p. 333; *Ibid.*, 1937, Claybury, visited 8 October 1937, p. 339.



Figure 10: Interior of Day Room, Admission Hospital, Ewell Mental Hospital, December 1936.

Source: LMA, General Subjects [Mental Hospital Photographs], SC/PHL/02/0584-78.

Asylum planners in the nineteenth century had already raised many of these connections between convalescence and privacy, domesticity, and liberty.¹⁸¹ In 1894, inspectors at ‘Chestnuts’, a home for quiet convalescing patients at Brentwood, Essex, particularly highlighted its ‘well-furnished,

¹⁸¹ J.T. Arlidge’s 1859 treatise on asylum design, *On the State of Lunacy*, had promoted the inclusion of a ‘separate section, of home-like character, regulated less as an asylum than as a family residence, and where the highest amount of liberty compatible with safety and order is the rule, would afford a most valuable means of treatment’, indicating a very similar concern for the domestication of convalescent homes, as the BoC would in the interwar period. Lunacy commissioners visiting North Riding Asylum in 1882, considered that the newly-converted female convalescent ward required bookcases ‘to render it suitable’ for its intended (private, and recovering) patients. J.T. Arlidge, *On the State of Lunacy and the Legal Provision for the Insane with Observations on the Construction and Organization of Asylums* (London: J. & A. Churchill, 1859), p. 145.

bright and cheerful' wards.¹⁸² Similar observations on the comfort and colour of convalescent villas recurred frequently in visiting inspectors' reports in the 1920 and 1930s. Ewell evidently met the Board's standards for internal decoration, when inspectors at its male convalescent villa in November 1936 commented its furnishings showed 'good taste'.¹⁸³ Its design directly embodied some of the Board's suggestions, and Figure 9 shows some of these in place just one month later. The lower ceiling height at 8 feet 6 inches resulted from the Board's cost-cutting expedients; any advantages to homeliness appear to have been incidental.¹⁸⁴ Smaller dimensions also helped distinguish the villa from the similarly-furnished admission hospital built at the same time, which featured identical seating, light-fittings, fireplaces, mirrors, and bookcases (compare Figures 9 and 10). Although motivated by economy, the villa's smaller dimensions arguably also contributed towards the 'home-like' feel sought by the BoC in convalescent villa planning.¹⁸⁵ A circular sent from the Board to the clerks of mental hospital visiting committees in 1928, raised 'the importance from a medical point of view of making the patients' surroundings as bright and cheerful as possible'.¹⁸⁶ Landscape portraits in Ewell's convalescent villa met the

¹⁸² Lunacy Commission, *Annual Report*, 1894, Brentwood, Essex, visited 13 June 1894, p. 230.

¹⁸³ BoC, *Annual Report*, 1936, Ewell, visited 5 November 1936, p. 303. Inspectors made similar comments on the furnishings and comfort of convalescent villas in a number of other cases. See BoC, *Annual Report*, 1930, Cornwall, visited 1 August 1930, p. 169; BoC, *Annual Report*, 1935, West Sussex, visited 25 September 1935, p. 361; BoC, *Annual Report*, 1936, Nottingham, visited 12 May 1936, p. 436; BoC, *Annual Report*, 1936, Brentwood, Essex, visited 20 August 1936, p. 244; BoC, *Annual Report*, 1936, East Sussex, visited 10 November 1936, p. 361; BoC, *Annual Report*, 1937, Northampton County, visited 23 February 1937, p. 374; BoC, *Annual Report*, 1937, Claybury, visited 8 October 1937, p. 339.

¹⁸⁴ LMA, London County Council, Ewell Mental Hospital Sub-Committee, Minutes, 25 May 1933, pp. 294-5; LMA, London County Council, Mental Hospitals Committee, General Purposes Sub-Committee, Minutes, 11 July 1933, pp. 308, 310.

¹⁸⁵ BoC, *Annual Report*, 1924, p. 15.

¹⁸⁶ TNA, Lunacy Commission and BoC, Circulars, O.E. Dickinson (Secretary, BoC), 719, April 1929.

Board's concern that these units in particular should feature wall decoration, as it was felt these patients were most likely to appreciate them.¹⁸⁷ Ewell's rustic pictures complemented and reinforced the BoC's interest in providing convalescents attractive views of the surrounding countryside, bringing artistic representations of such idyllic scenery inside the domestic sphere.

Aside from variation in their size, the interior views of the convalescent villa and admission hospital completed at Ewell in 1936 are remarkably similar. The design of such units, as well as their grouped position in a separate part of hospital sites, identified the connectedness of the functions they performed. Following the ideal progression envisaged by the BoC, patients would pass from the admission hospital to 'ancillary' convalescent villas. At Ewell, these villas were smaller, and perhaps therefore more homely in appearance, but similar enough to preserve a sense of continuity in treatment. George Gibson's comments in 1936 on Brentwood's recently-opened admission hospital, described it in terms that were very similar to the Board's ideal convalescent home. In particular, he admired its 'homey' atmosphere, and bright paint and chintz curtains, which he felt 'completed a decorative scheme which screamed "comfort"'.¹⁸⁸ Homeliness, colourful decor, and comfort introduced into such admission hospitals, and replicated in adjacent convalescent villas, served to sustain a feeling of domesticity and connectedness with the outside world throughout treatment. By the late 1930s, admission hospitals and convalescent villas started to be referred to

¹⁸⁷ Ibid.

¹⁸⁸ George Gibson [general secretary, Institutional and Mental Health Workers' Union], 'Warleywoods Hospital: Opening of the New Reception Hospital at Brentwood', *Mental Health and Institutional Workers' Journal* 25:7 (July 1936), p. 2.

as 'early treatment centres'.¹⁸⁹ This name identified their combined function in treating and discharging patients still in the early stages of mental illness, and recently arrived from the community, in a self-contained part of the mental hospital site. The wireless shown at Ewell's convalescent villa, found at other villas in neighbouring Long Grove, allowed its residents indirect contact with the outside world, shared by nine million households in Britain by 1939.¹⁹⁰

3. Local Authorities and the Emergence of the Convalescent Villa: The Case of the London County Council, 1902–39

As Chapter One has explored, the London County Council played an instrumental role after 1900 in the introduction and adaptation of continental and Scottish ideas on villa design into English asylum planning. It has been suggested that asylum planners such as the architect G.T. Hine, asylums engineer Clifford Smith, and medical superintendent T.E.K. Stansfield only retrospectively formulated a therapeutic continuum between recent admission, and convalescence leading to discharge. Indeed, during 1903–04 Smith and Stansfield further altered plans for a new asylum (Long Grove: 1907) based on Maryland Asylum in the US, to provide a 'hospital section' that included not only a hospital for recent cases and convalescent villa, but

¹⁸⁹ The first instance of the BoC's use of the term 'early treatment centres' that I have found was made in 1937, when they applied it to units planned at Winwick and Lancaster. Thereafter, this usage of 'early treatment centres' appears to have become widely accepted. See BoC, *Annual Report*, 1937, p. 23; 'The Cost of Hospitals: Departmental Committee's Recommendations', *Mental Health and Institutional Workers' Journal* 27:6-7 (June and July 1938), p. 6; BoC, *Suggestions and Instructions for the Arrangement, Planning and Construction of Mental Hospitals* (London: H.M. Stationary Office, 1941), p. 5; F.C. Webster, 'Modern Trends in the Planning of Mental Hospitals and other Psychiatric Units in England', *Journal of Mental Science* 44 (January 1948), p. 100.

¹⁹⁰ LMA, London County Council, Asylums and Mental Deficiency Committee, Presented Papers, BoC report on visit to Long Grove, 19-21 October 1937, p. 1.

other sections for acute patients. Although their focus on 'recoverable' patients provided the conceptual basis for the interwar admission hospital and convalescent villa, it nevertheless covered a wider range of patients at this stage.¹⁹¹ In turn, the LCC's Asylums Committee's vote was split on whether to implement Smith and Stansfield's plans, or whether to replicate Hine's plans for Bexley and Horton.¹⁹² As in much of the rest of the country, the authority only added admission hospitals and convalescent villas at its existing institutions in the interwar period (see Appendix 1). Consequently, it is after 1919 that the primary principle of convalescence as a phase that should follow immediately after reception into an admission hospital, developed gradually over the 1890–1910s, was widely implemented at the majority of the LCC's asylums.

It does seem that the LCC had begun to consider modernisation at its older asylums before the war, yet the conflict and subsequent recession meant that in practice such plans remained confined to the drawing board.¹⁹³ After 1919, however, the LCC widely added units for recent and convalescent patients. Consistent with emerging BoC policy, the LCC Mental Hospitals Committee committed itself in 1923 to 'extensive and costly' rebuilding at Hanwell and Colney Hatch, on the basis that they fell short of 'present views as to what is ideal accommodation'.¹⁹⁴ By 1933, Banstead, Hanwell, Colney Hatch and Claybury had all opened admission hospitals,

¹⁹¹ LMA, LCC, Asylums Committee, Accommodation Sub-Committee, Minutes, 19 May 1903, p. 29, 24 November 1903, pp. 162-7, 21 June 1904, pp. 170-1.

¹⁹² Cochrane, 'Humane, Economical, and Medically Wise', p. 259; LMA, London County Council, Asylums Committee, Accommodation Sub-Committee Minutes, 26 September 1904, p. 79.

¹⁹³ *Annual Report of the London County Council, 1915–19* (London: London County Council, 1920, p. 25.

¹⁹⁴ LMA, London County Council, Mental Hospital Committee, Minutes, 1923, volume I, p. 545.

with further units planned for Claybury and Ewell (see Appendix 2). David Cochrane's observation that the LCC's asylums had added a few villas 'here and there' in the interwar period therefore arguably underplays the symbolic significance the LCC attached to these units.¹⁹⁵ It seems that the LCC's Chief Officer R.H. Curtis – like the BoC – envisaged admission and convalescent villas as part of a process of interwar asylum reform. In an article published in 1939, Curtis drew attention to the transformative effect the villas that the LCC had added 'here and there', which he felt had helped 'remodel and improve some of the less satisfactory features' at older institutions.¹⁹⁶ Moreover, the newly-built convalescent villa served as a clearing house into what Mathew Thomson has characterised as London's 'surprisingly well-developed and integrated community care network' for mental health.¹⁹⁷ Their significance should therefore arguably be appraised in the light of a broader attention to the period of mental convalescence in London's asylums, further reflected in the cooperativeness of the LCC with the MACA, and extensive use of its voluntary cottage homes for convalescents (see Chapter Three).

During the 1920s, the LCC took an active part in official debates on the importance of the detached admission and convalescent units it had helped pioneer in England. In evidence to the Macmillan Commission in May 1925, the Council stated that it placed the 'greatest importance' on these units, and perhaps more clearly than the BoC at this date, emphasised their value in allowing patients to recover without recourse to other hospital wards.

¹⁹⁵ Cochrane, 'Humane, Economical, and Medically-Wise', pp. 266, 272.

¹⁹⁶ R.H. Curtis (Chief Officer, LCC Mental Hospitals Committee), 'Then and Now: The L.C.C. Mental Hospitals', *Medical Press and Circular* (12 July 1939), p. 32.

¹⁹⁷ Mathew Thomson, 'Social Policy and the Management of the Problem of Mental Deficiency in Inter-war London', *London Journal* **18** (November 1993), p. 138.

Due to Stansfield and Clifford Smith's initiatives, the LCC Mental Hospitals Committee was able to report the presence of separate admission and convalescent units at all its later mental hospitals, as recommended by the 1922 Cobb Report. At the same time, it acknowledged the desirability, 'as opportunity permit', of adding villas to the older hospitals under its control.¹⁹⁸ G.F. Barham, superintendent at the LCC hospital of Claybury, had recently presented this same viewpoint to a wider professional audience at the BoC's April 1925 conference on 'Mental Hospital Accommodation'. At a conference convened to address institutional overcrowding, Barham's paper 'Building at Existing Mental Hospitals' addressed the addition of admission and convalescent units. These were the first additions considered in Barham's discussion, suggesting their perceived importance. In an indication of the LCC and BoC's shared outlook on institutional redevelopment, the Board's Chairman Frederick Willis endorsed Barham's paper, and his suggestion for admission hospitals, in a July 1925 circular on overcrowding.¹⁹⁹ In turn, Curtis wrote that Willis's suggestions met the LCC's own need for further asylum accommodation. Furthermore, Curtis pointed to the admission units under development at Claybury and Colney Hatch as evidence that the LCC was already meeting the BoC's current agenda, suggesting that the authority remained in the van of new developments.²⁰⁰

¹⁹⁸ LMA, London County Council, Mental Hospitals Committee, Presented Papers, memorandum of evidence to the Royal Commission on Lunacy and Mental Disorder, 19 May 1925; *London County Council Minutes of Proceedings, 1925, Volume I* (London: London County Council, 1925), 5 and 19 May 1925, p. 881.

¹⁹⁹ TNA, Lunacy Commission and Board of Control, Circulars, F.J. Willis, 'Mental Hospital Accommodation', 664, 21 July 1925, p. 1.

²⁰⁰ LMA, LCC, Mental Hospitals Committee, Presented Papers, R.H. Curtis 'Circular Letter of the Board of Control as to Accommodation', 28 July 1925, p. 1.

Following the BoC's *Memorandum on the Mental Treatment Act* in September 1930, the LCC set-up its own special sub-committee to consider its implications. The Board's *Memorandum* concluded that good reception and convalescent units would suffice to meet the needs of voluntary patients.²⁰¹ Reporting on 4 December, the LCC's sub-committee reached similar conclusions, whilst again interpreting them within the context of local needs, on the guidance of local experts. Based partly on the testimony of J.R. Lord as spokesman for the LCC's superintendents, the council's Mental Treatment Act Sub-Committee agreed that voluntary and certified admissions should be conjointly received into 'adequate admission villas or... units'.²⁰² Nevertheless, unlike the BoC, which was pressing for the universal addition of admission hospitals, it felt the Council would not require more units than already in progress. Instead, it proposed concentrating temporary treatment on Ewell, which already featured multiple villas and was in the process of reconstruction, while retaining voluntary treatment at the Maudsley.²⁰³ In a second report of 12 February 1931, the Sub-Committee further suggested that besides rate-assisted cases, Claybury and Horton should also receive a concentration of private voluntary cases.²⁰⁴ With the large number of institutions under the LCC's control, and good provision of admission and convalescent villas, the Council was able to contemplate

²⁰¹ TNA, Lunacy Commission and Board of Control, Circulars, 745, 'Memorandum on the Mental Treatment Act, 1930', September 1930, pp. 1-2.

²⁰² LMA, London County Council, Mental Hospitals Committee, Minutes of Special Sub-Committees, Mental Treatment Act Sub-Committee minutes, 6 November 1930, pp. 163-4; LMA, London County Council, Mental Hospitals Committee, Minutes of the General Purposes Sub-Committee, 9 December 1930, p. 392.

²⁰³ LMA, LCC, Special Sub-Committees, LCC/MIN/756-7, Minutes, 1926-39, Mental Treatment Act Sub-Committee, Minutes, 6 November 1930, pp. 163-4; LMA, London County Council, Mental Hospitals Committee, Minutes of the General Purposes Sub-Committee, 9 December 1930, p. 393.,

²⁰⁴ *Ibid.*, 17 February 1931, p. 443.

specialisation across its institutions, which together stalled the need for further construction to meet the Act's provisions.²⁰⁵ In consequence, the Act – which promised an increase in precisely the sort of early and treatable patients that admission and convalescent villas were designed to receive – seems to have had relatively little effect on further developments in the number or layout of onsite convalescent accommodation.

The LCC's earliest admission and convalescent units had provided a template for the BoC's interwar policies; from the 1920s, the BoC in turn encouraged the LCC to monitor its own progress in extending these to its older hospitals. In response to the second BoC circular on 'Mental Hospital Accommodation', distributed in May 1931, the LCC Mental Hospitals Committee asked the chief officer to investigate opportunities for increasing beds through admission and convalescent units across hospitals 'not yet furnished with such units'.²⁰⁶ R.H. Curtis's survey of July 1931 illustrated the LCC's ongoing engagement with these works, which were then in progress at Banstead and Hanwell (see Appendix 2). At the same time, it also revealed continuing gaps in provision, particularly of male convalescent villas, which were present in just four hospitals of the ten surveyed (compared with nine with female villas). The survey is suggestive of the LCC's receptivity to this aspect of BoC policy, even though it does not appear to have led to any new villas, beyond those already planned, before 1939. Visiting inspectors to Horton would specifically call for a male

²⁰⁵ The number of the LCC's mental hospitals (11) was only approached by Lancashire (5), West Riding (4), Middlesex and Staffordshire (3 each).

²⁰⁶ LMA, London County Council, Mental Hospitals Committee, Minutes, 23 June 1931, p. 563.

convalescent villa in 1936.²⁰⁷ On the BoC's advice, Horton's sub-committee enlarged existing plans for more male accommodation, to incorporate a villa previously used for private female patients.²⁰⁸ So too, the BoC's inspectors at Cane Hill in 1937 complained its centralised admission ward lacked facilities for 'proper classification', and particularly recorded their concern for the 'somewhat disturbing' placement of females in the male admission ward.²⁰⁹ Such complaints were relatively rare, however, and by this date the majority of the LCC's older asylums had been equipped with either purpose built, or converted admission and convalescent units. Although gaps remained, compared with many other councils the LCC could point to significant progress.

Plans for further convalescent accommodation were already in progress at Claybury, at the commencement of the Mental Treatment Act Sub-Committee's discussions, and Curtis's survey. Claybury Sub-Committee had begun contemplating the erection of a fifteen-bed male convalescent home in June 1930, and plans were conditionally commenced in the November.²¹⁰ This illustrates again the advanced state of the LCC's plans for the reform of its existing hospitals at this date. In July 1931, however, just two days after Curtis's report, Claybury's medical superintendent, G.F. Barham, submitted a report on the desirability of substituting a combined

²⁰⁷ BoC, *Annual Report*, 1936, Horton, visited 19 March 1936, p. 310.

²⁰⁸ To compensate the reduction in female villas during the reorganisation, an additional villa was planned for tubercular and infirm female patients. LMA, London County Council, Mental Hospitals Committee, Special Sub-Committees, Minutes, report of the Building and Accommodation Section, 30 November 1937, pp. 397-8.

²⁰⁹ BoC, *Annual Report*, 1937, Cane Hill, visited 10 September 1937, p. 336.

²¹⁰ LMA, London County Council, Claybury Mental Hospital Sub-Committee, LCC/MIN/959-65, 1925-48, Minutes, 6 November 1930, p. 222.

male reception and convalescent block in place of the single home.²¹¹ The timing of Barham's suggestion circumstantially hints at the influence of Curtis's investigations into accommodation for recoverable cases, which itself had resulted from the BoC's circular of May 1931.²¹² As a larger unit for fifty patients, Barham's proposal more closely corresponded to three aspects of BoC policy. Firstly, it provided for both recent and convalescent patients, secondly, it offered to alleviate overcrowding, and, thirdly it would provide further beds to meet the needs of the new class of voluntary patients. Moreover, BoC inspectors had recently described the conjoint arrangements for female patients at Forest House, opened at Claybury in November 1928, as 'excellent'.²¹³ As a result, they were likely to have viewed Barham's proposal as preferential to the single home originally planned for male patients. At the same time, however, the LCC was also acting on its initiative to review construction, independently of the BoC. Its appointment in June 1931 of a 'Special Section on Accommodation' to coordinate larger building works allowed the Council to internally debate and critique BoC revisions and suggestions in detail. While meeting many of the BoC's interests, the LCC also continued to review works according to its own criteria.

Barham took an active role expediting the construction of the new units. Along with five members of the hospital's visiting committee, he visited Newcastle's admission unit in August 1931 to study the arrangement of its

²¹¹ Ibid., 16 July 1931, p. 374.

²¹² Books of papers presented at mental hospital committees only rarely survive for LCC mental hospitals prior to World War Two, when many volumes were destroyed, although they survive locally for some years (as at Claybury, after 1937). Their absence makes attributing local decisions more difficult, as the original reports no longer exist, although minutes and the Mental Hospitals Committee's presented papers give some indication of causality.

²¹³ BoC, *Annual Report*, 1930, Claybury, visited 5 December 1930, p. 221.

admission ward.²¹⁴ He was also responsible for recommending the preparation of plans ahead of clearance from the finance committee 'to obviate delay'.²¹⁵ Nevertheless, as elsewhere in the country, economic events impeded plans for development. The LCC's General Purposes Sub-Committee intervened in October, asking R.H. Curtis to assess 'the need for pressing forward, at the present juncture' with Claybury's plans. The title of Curtis's report – 'Economic Situation – Possible Savings – Need for Additional Accommodation for Patients of Unsound Mind' – succinctly summarised the competing imperatives of medical and managerial need, and financial infeasibility, which Curtis sought to address.²¹⁶ Curtis proved overly ambitious in his projection that the units at Claybury would be completed by the second half of 1933.²¹⁷ During 1933/4, Claybury's Sub-Committee could only ask the architect to prepare further plans, 'in anticipation of the time when money will be available to carry out the work'.²¹⁸ Delays to the LCC's modernisation and expansion plans were nevertheless generally less severe than at many other authorities, such as Buckinghamshire, Norfolk and Cambridgeshire.²¹⁹ This was perhaps due in part to Barham's preparatory planning and the resources at the Council's disposal, as much as the Council's pre-existing commitment to modernising its older hospitals. Plans

²¹⁴ LMA, London County Council, Claybury Mental Hospital Sub-Committee, Minutes, 10 September 1931, p. 401.

²¹⁵ *Ibid.*, 8 October 1931, p. 420.

²¹⁶ LMA, London County Council, Mental Hospitals Committee, Presented Papers, Chief Officer [R.H. Curtis], 'Economic Situation – Possible Savings – Need for Additional Accommodation for Patients of Unsound Mind', 3 November 1931.

²¹⁷ LMA, London County Council, Mental Hospitals Sub-Committee, Presented Papers, Chief Officer [R.H. Curtis], 'Additions to Accommodation for Patients which will Result if and When Schemes which have been Approved or have been Mooted are Completed', 3 November 1931, p. 5.

²¹⁸ LMA, London County Council, Mental Hospitals Committee, Claybury Mental Hospital Sub-Committee, Minutes, 26 January 1933, pp. 3-5.

²¹⁹ Crammer, *Asylum History*, pp. 142-3; Cherry, *Mental Health Care in Modern England*, pp. 245, 313; David H. Clarke, *The Story of a Mental Hospital: Fulbourn, 1858-1983* (London: Process Press, 1996), chapter 6.

at Claybury received the BoC's approval in October 1934, and 'Orchard House' opened for male patients slightly over three years behind schedule in April 1937.²²⁰ At Ewell too, the designs for a male convalescent villa and admission hospital that had been on the drawing-board in February 1933 were already in occupation by the middle of 1936.²²¹

Whilst the relatively rapid timetable for the completion of Claybury and Ewell's villas suggests the recession had a comparatively minor impact on the LCC's plans, questions over their design clearly reflected contemporary budgetary concerns. In February 1933, the Building and Accommodation Section recommended the omission of a kitchen planned for Claybury's new admission and convalescent unit. The Section argued that serving patients from central rather than local kitchens would save equipment, staff, and administrative costs, and represented the first of several 'substantial economies' that might be made in planning the unit.²²² After an adjourned discussion, the Claybury Sub-Committee resolved instead in favour of retaining separate kitchens. Again based on the testimony of Barham, the sub-committee agreed that the advantages of a 'more distinct and attractive type of local kitchen service' outweighed 'any small economy' that would result from its exclusion from the new unit.²²³ Unsuccessful trials of a remote meal supply from neighbouring Claybury Hall, had convinced Barham in

²²⁰ LMA, London County Council, Mental Hospitals Committee, Claybury Mental Hospital Sub-Committee, Minutes, 4 October 1934, p. 306.

²²¹ BoC, *Annual Report*, 1936, Ewell, visited 5 November 1936, p. 303; LMA, London County Council, Ewell Mental Hospital Sub-Committee, Minutes, 23 April 1936, p. 524.

²²² LMA, London County Council, General Purposes Sub-Committee, Building and Accommodation Section, Minutes, 14 February 1933, p. 7; LMA, London County Council, Mental Hospitals Committee, Claybury Mental Hospitals Sub-Committee, Minutes, 23 March 1933, pp. 54-5.

²²³ LMA, London County Council, Claybury Mental Hospital Sub-Committee, Minutes, 27 July 1933, p. 118.

1928 that Forest House should have its own kitchen, where patients would help a staff assistant with duties.²²⁴ The practice became widespread amongst the villas in the LCC's hospitals. Indeed, the arrangement had already been tried, tested, and approved at the Heath [Bexley], on its sub-committee's recommendation in 1901.²²⁵ By 1937, West Park had eleven units with dedicated facilities for cooking.²²⁶ Integral kitchens had been promoted in connection with convalescent homes in the BoC's 1924 guidelines, to create a more self-contained, separate, and home-like atmosphere.²²⁷ In the altered recessionary climate of the early 1930s, however, the LCC, and elsewhere the BoC, were suggesting their omission to save money.²²⁸ Nevertheless, Claybury's stance in favour of integral kitchens prioritised local experience and decision-making over such cost-cutting imperatives.

At Ewell, the recession had a more significant impact on the shape of its male convalescent villa. The hospital's sub-committee wrote to the BoC in the middle of 1932, soliciting the commissioners' views on the acceptable size of dayrooms for patients across all its proposed extensions, including the villa. It was informed that while the BoC would normally encourage a standard of '30 superficial feet per patient', it would not press the LCC to comply with this 'in view of the present financial crisis'.²²⁹ Smaller

²²⁴ Ibid., 1 March 1928, 15 March 1928, pp. 164, 188.

²²⁵ LMA, London County Council, Asylums and Mental Deficiency Committee, LCC/MIN/584-603, Minutes, 1919-39,, 13 June 1901, pp. 188-9.

²²⁶ BoC, *Annual Report*, 1937, West Park, visited 31 August 1937, p. 358

²²⁷ Ibid., 1924, p. 15.

²²⁸ Lawrence Brock (Chairman, BoC) also suggested in 1932 that West Riding might dispense with kitchens to save costs, indicating that at some level at least, similar proposals and decisions were being taken elsewhere in England. See TNA, Lunacy Commission and BoC, 'Wadsley', 'J.H.C.', summary case-history, 29 July 1932.

²²⁹ TNA, Lunacy Commission and Board of Control, Minutes, 28 July 1932.

dimensions, which the BoC had previously recommended in 1924 for encouraging an environment of homeliness, in the early 1930s was presented for the quite different motive of reducing capital expenditure. Ewell's Sub-Committee in turn set budgetary limits and proposed to reject BoC amendments to the design of its convalescent home, if it was found on investigation that costs would be 'considerably increased'.²³⁰ It proved more willing, however, to approve the BoC's recommended reduction in the height of rooms at the home to 8ft 6ins, and simply recorded its desirability 'as a matter of economy'.²³¹ The Building and Accommodation Section also approved the proposal, yet pointed to different reasons in favour of smaller interior dimensions. Instead, the Section felt that ventilation would be improved by bringing ceilings closer to the tops of the windows and therefore would benefit patients. So too, in quoting the BoC recommendation, the Section's minutes highlighted the importance of designing the convalescent villa on 'domestic lines', suggesting that it drew an equivalence between smaller scale and homeliness.²³² Such divergent reasoning illustrates the susceptibility of even single spaces to multiple functional evaluations. Significantly, the LCC's sub-committees took an active role in this process of 'translation', interpreting the value of modifications to convalescent villa design according to local criteria.²³³

²³⁰ LMA, London County Council, Ewell Mental Hospital Sub-Committee, Minutes, 2 February 1933, p. 271.

²³¹ *Ibid.*, 25 May 1933, pp. 294-5.

²³² LMA, London County Council, General Purposes Sub-Committee, Building and Accommodation Section, Minutes, 4 July 1933, p. 14; LMA, London County Council, General Purposes Sub-Committee, Minutes, 11 July 1933, pp. 308, 310.

²³³ William Whyte, 'How do Buildings Mean?: Some Issues of Interpretation in the History of Architecture', *History and Theory* **45** (May 2006), pp. 153-4.

Medical superintendents, such as Barham, took a prominent role critically engaging with the BoC's policy on convalescent villas, and adapting it to suit local context. Like BoC inspectors, A.A.W. Petrie (Medical Superintendent, Banstead) and Barham showed a particular concern for preserving good views for recoverable patients. At Banstead, Petrie recommended that shrubs should be planted between the admission villa and detached hospital, which he considered 'somewhat ugly', in order to 'form a screen to hide this unpleasant vista'.²³⁴ Petrie therefore privileged the perspective of recent patients looking out from the admission villa, focusing on an aesthetic improvement designed to obscure an undesirable institutional feature, with a natural barrier. Similar planting had already been added between the main asylum and units for recoverable patients at West Park, which BoC inspectors in 1925, like Petrie, interpreted as a useful visual 'screen'.²³⁵ On a wider scale, in 1937 Barham raised the encroachment of north-east London's suburbs on Claybury's perimeter, and proposed the plantation of 500 Lombardy poplars along the whole south side to 'ensure the view from the estate shall not... suffer too much'. In his report, Barham particularly raised the benefit of these views to the private patients in Claybury Hall, and the recent and convalescent patients in Forest House, which occupied sites closest to the southern boundary. It was, however, not the proximity of these buildings to the new-build suburbs that Barham emphasised, but rather the 'very great asset' that the vanishing 'peaceful and

²³⁴ LMA, London County Council, Banstead Mental Hospital Sub-Committee, LCC/MIN/800, Minutes, 1930-33, 14 March 1932, p. 381.

²³⁵ BoC, *Annual Report*, 1925, West Park, visited 16 November 1925, p. 256.

country view' had provided the residents of these buildings.²³⁶ While screens between Claybury and the outside community were considered to benefit the hospital as a whole, Barham, like Petrie, showed a particular concern for the views accessible to the most recoverable and privileged patients under institutional care.²³⁷

Just as Barham had rejected the centralisation of kitchens, so in 1935 he again asserted his professional expertise in calling upon the Claybury Sub-Committee to disregard the BoC's suggestion for the extension of gardens around the future Orchard House. Although neither he, nor the Sub-Committee ruled-out changes to the gardens in future, Barham felt that the 'open country in front of the proposed villa... obviated the need for extensive grounds'. So too, he argued against the 'visible demarcation' that he felt were implicated in the Board's plans, which brought the gardens to the edge of the diverted path.²³⁸ Taken together, it seems that Barham was primarily concerned to make the unit appear as open as possible; aims which again matched those of the BoC's own guidelines for open-door policies in all convalescent villas.²³⁹ Like the BoC, Barham seems to have considered the area immediately surrounding buildings for recent and convalescent patients as less important than their situation relative to the wider landscape. In 1937, Barham again raised the particular importance of the 'amenities provided by

²³⁶ LMA, London County Council, Claybury Mental Hospital Sub-Committee, LCC/MIN/966, Presented Papers, 1937-8, 28 October 1937, p. 9.

²³⁷ Chris Philo has noted the prevalence of encroaching urbanisation on the margins of English asylums from the nineteenth century, suggesting that these problems and concerns may possibly have been encountered more widely. See Chris Philo, 'Scaling the Asylum: Three Geographies of the Inverness District Lunatic Asylum (Craig Dunain)', in Leslie Topp, James E. Moran, and Jonathan Andrews (eds), *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (Abingdon, Oxon; and New York: Routledge, 2007), p. 114.

²³⁸ LMA, London County Council, Claybury Mental Hospital Sub-Committee, Minutes, 22 August 1935, p. 455.

²³⁹ BoC, *Annual Report*, 1924, p. 15.

the park and plantations' to neighbouring Forest House, and to the private residents of Claybury Hall.²⁴⁰ Despite his concern to avoid visibly compartmentalising outdoor spaces for recoverable patients, however, Barham also wanted poplars that would preserve recoverable patients' separation and seclusion from the encroaching suburbs. At Ewell the presence of a public bridleway running close to the site of the new admission unit and villa, prompted the Sub-Committee to erect a 6ft chestnut fence, as a 'temporary enclosure'. It was also, however, provided with a gate through which parole patients could pass.²⁴¹ In both cases, the trees and the fence shielded recoverable patients from constant exposure to the public, fostering a sense of elective invisibility.

4. Conclusion

Viewed from the perspective of convalescent treatment, many English mental hospitals had changed substantially between 1919 and 1939. The widespread development of detached units (at least at the planning stage, if not always fulfilled) is particularly surprising considering the targeted reductions in health expenditure imposed by the reports of the Geddes and Ray committees.²⁴² Although Alexander Walk has perhaps overstated their universality by 1939, it is certainly evident that most mental hospitals had at

²⁴⁰ LMA, London County Council, Claybury Mental Hospital Sub-Committee, Presented Papers, 28 October 1937, p. 9.

²⁴¹ LMA, London County Council, Ewell Mental Hospital Sub-Committee, Minutes, 25 April 1935, p. 436.

²⁴² Malcolm Richardson, 'Education and Politics: The London Labour Party and Schooling between the Wars', in Andrew Saint (ed.), *Politics and the People of London: The London County Council, 1889-1965* (London and Roncerverte, WV: Hambledon, 1989), p. 151.

least begun contemplating plans for these units by this date.²⁴³ In the twelve years that BoC inspection reports were included in the BoC's annual reports, inspectors called for updated convalescent accommodation in more than half of all English mental hospitals. The LCC's introduction of villas into its newest asylums built after Bexley in 1898, which were based on an interpretation of continental and North American planning, provided a model for the BoC's interwar policies on convalescent villa design. Meanwhile, Montagu Lomax's *Experiences of an Asylum Doctor* of 1921, and the subsequent investigations of the Cobb and Macmillan committees, challenged the *status quo* of England's old asylums, and a created a climate ripe for reformism.²⁴⁴ While many of the newest hospitals built after Bexley already featured separate and dedicated admission hospitals and convalescent villas, the BoC and LCC's policies in the interwar era turned to the modernisation of older institutions. Both authorities considered these units sufficiently important to pursue their introduction at even the largest of their hospitals (many of which, such as Claybury, were in London), despite the Ministry of Health's concern to limit the size of mental hospitals, and cut costs.

Intramural accommodation for convalescents, as local case studies suggest, varied significantly at a local level by 1939. Economic recession both slowed and shaped provision at a local level, in some cases contributing (with war) to delays of several decades in the realisation of convalescent

²⁴³ Walk, 'Mental Hospitals', p. 11; Levene, Powell, and Stewart, 'Patterns of Municipal Health Expenditure', p. 653; Martin Powell, 'An Expanding Service: Acute Medicine in the 1930s', *Twentieth Century British History* 8 (September 1997), pp. 341-2.

²⁴⁴ John Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', *History of Psychiatry* 10 (August 1999), pp. 351-2; Harding, 'Not Worth Powder and Shot', pp. 180-1; Long, 'Changing Representations of Mental Illness', pp. 59-61; Crammer, 'English Asylums and English Doctors', p. 110.

villas, whilst in others leading to investigations into possible economies in their design.²⁴⁵ As the divergent accounts of Edward Myers and John Hopton (amongst others) have suggested, and BoC institutional reports evidence, local authorities responded at different times, and in different ways to the BoC's policy on institutional redevelopment.²⁴⁶ The result was a continued lack of uniformity in approaches to convalescence across England's mental hospitals by 1939, although a common framework and greater consistency existed by this date than in 1919. Without executive control over spending, the BoC could only encourage and cajole authorities to meet its revised expectations on the separate treatment of supposedly 'recoverable' cases. Despite the BoC's growing interest in coordinating a consistent approach to early and convalescent treatment across England (and Wales), analysis of the LCC's deliberations suggests local authority committees played an important role implementing, interpreting, and modifying plans to meet local needs. The relatively rapid introduction of admission and convalescent villas at the LCC's asylums seems to have owed much to the input of superintendents such as T.E.K. Stansfield and later G.F. Barham. Villa design was shaped by a desire to enhance healthful contact between

²⁴⁵ For instance, Northumberland and Cumberland both commenced plans for admission hospitals and convalescent villas by the mid-1930s, which eventually opened in the late 1950s and early 1960s, while Steven Cherry and John Crammer both attribute ongoing delays in the erection of blocks for recent patients at Norfolk and Buckinghamshire to a combination of budgetary restrictions and war. See Cherry, *Mental Health Care in Modern England*, pp. 173, 206, 245, 271; Crammer, *Asylum History*, pp. 142-3.

²⁴⁶ All three of Staffordshire's mental hospitals completed admission hospitals and convalescent villas before 1939, although Myers notes that those at Cheddleton were not opened until after the Second World War. In contrast, Hopton has questioned why Prestwich, which became the centre of reformist debate after Montagu Lomax's *Experiences of an Asylum Doctor* in 1921, failed to realise many of its planned reforms. Despite pressure from the BoC, Prestwich was among those hospitals to still not have commenced plans for an admission hospital and convalescent villas by 1939. See Hopton, 'Uneven Progress', p. 365; Edward D. Myers, *A History of Psychiatry in North Staffordshire* (Leek: Churnett Valley, 1997), p. 132.

convalescents and their surrounding environment, but also reflected budgetary constraints and managerial imperatives.

Niall McCrae and Andrew Scull have argued that the inclusion of detached admission hospitals and villas within the existing space of the asylum, diluted their significance, leaving them immersed in a 'stultifying', 'segregative', and essentially Victorian institutional regime.²⁴⁷ This relative proximity to other classes of patients, however, potentially served to reinforce patients' sense of convalescent identity, as Chapter Four will explore further. Kerry Davies's study of patient oral histories at Littlemore Hospital, Oxford, has found that residents 'used ward differentials to place themselves within the system in relation to others'.²⁴⁸ The BoC's advice and comments on convalescent spaces in English mental hospitals, and the LCC's plans for these units suggests onsite villas were intended to foster a sense of domesticity, seclusion, and freedom, which identified residents with community life rather than institutional treatment. In particular, these plans aimed at a reorientation of mental treatment from one of 'sickness and cure' to one of early treatment and rehabilitation, which preserved aspects of the patient's former domestic environment, and prevented them from passing into the institutional space of the old 'asylum'. The shift from 'asylum' to 'mental hospital', which Lindsay Prior has identified taking place between 1926 and 1930, was therefore closely associated with the emergence of new

²⁴⁷ Scull, 'Decarceration', pp. 112-3; McCrae, 'Violent Thunderstorm', p. 69.

²⁴⁸ Erving Goffman has argued that while convalescents might perceive a significant distance between their own wards and the 'back wards' for chronic patients, each group is likely to identify locally with the social environment created in their own ward, creating a more positive sense of belonging. See Kerry Elisabeth Davies, 'Narratives Beyond the Walls: Patients' Experiences of Mental Health and Illness in Oxfordshire since 1948' (unpublished PhD thesis, Oxford Brookes University, 2002), p. 99; Erving Goffman, *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates* (London: Penguin, 1991 [1961]), p. 121.

sites of active and rehabilitative treatment within the newly rechristened 'hospital' walls.²⁴⁹ Convalescent villas particularly privileged the connection of their residents to the surrounding landscape, whether imaginatively, through landscape portraits, railway posters, and windows with good views, or physically, through the extension of parole. Prior has elsewhere argued that the separation and domestic furnishing of 1970s psychiatric day hospitals maintains 'the echo of that "community" which is assumed to lie beyond the hospital walls'.²⁵⁰ This chapter has suggested that such emulative and rehabilitative domestic spaces were central to the BoC and LCC's reinvention of the 'mental hospital' as a suitable and explicitly 'modern' place of medical treatment.

While convalescent villas can tell historians much about their intended therapeutic function, their emergence and design also reflected contemporary non-medical concerns. BoC circulars and reports made clear their value in alleviating widespread institutional overcrowding present in English mental hospitals, and thereby emphasised managerial as well as medical incentives for their completion. So too, the BoC's claims to convalescent villas' modernity potentially contributed to a more progressive image of mental hospital treatment, in a period when Montagu Lomax's work, and ensuing public inquiries, raised questions over the therapeutic role of public psychiatric institutions. At the same time, the spread of convalescent villas, and decisions over their design, were to some degree constrained by the Ministry of Health's efforts to restrict capital expenditure and limit the size

²⁴⁹ Prior, *Social Organization of Mental Illness*, pp. 29-30.

²⁵⁰ Lindsay Prior, 'The Architecture of the Hospital: A Study of Spatial Organization and Medical Knowledge' *British Journal of Sociology* **39** (March 1988), pp. 108-9.

of mental hospitals, and legal constraints on the development of offsite convalescent annexes. Suburban encroachment onto the margins of hospital estates, the layout of existing buildings, and availability of land further influenced the location, demarcation, and linkage of these units with other institutional and extra-institutional zones. These complex justifications for initiating convalescent villas, and for designing them in particular ways, as William Whyte and Lindsay Prior have argued more generally, affirm the importance of embedding any interpretation of their use in contemporary discourse.²⁵¹ LCC medical superintendents and sub-committees and BoC inspectors and commissioners all individually assessed the importance of convalescent villas from a variety of medical, social, economic, and managerial perspectives. To the BoC, most prominence was given to a 'modern' classification, which would distinguish clearly, and with an increased spatial distance, between 'recoverable' (particularly the recent and convalescent) and irrecoverable patients. Nevertheless, overcrowding and stigma catalysed their development, while recession and constraints on land-use influenced decision-making on their final shape.

Ultimately, however, the introduction of convalescent villas made convalescence itself more visible within English mental hospitals after 1919. Resituated within an institutional sub-site of the old asylum, convalescents were thereafter more clearly identified with a new 'hospital' ideal of treatment, in which recoverable certified – and after 1931, uncertified – admissions could be treated separately until cure. Historians have largely concentrated on developments outside mental hospitals between 1919 and

²⁵¹ Ibid., pp. 86, 90-1; Whyte, 'How do Buildings Mean', pp. 171-3.

1939. Nevertheless, this chapter has suggested that to comprehend changing attitudes to convalescence and treatment generally, it is also necessary to look inside these institutions. The small scale and domestic comfort of interwar convalescent villas bore strong similarities with nineteenth-century antecedents. Yet their location and placement within the hospital site also reflected contemporary concerns with mental hygiene, prevention, and the diminution of institutionalisation for the most curable cases.

Chapter Three: The Voluntary Cottage Home in Convalescence, 1919–39

1. Introduction

Concurrent with the widespread development of mental hospital convalescent villas, the interwar period also witnessed strong growth in voluntary services for the convalescent patient. This chapter considers the changing relationship between the local authority and voluntary sectors in the provision of convalescence, as a practice that throughout this period co-extended across institutions and the community. Chapters One and Two have suggested convalescence became a more visible and central part of mental hospital treatment, through the construction of paired admission hospitals and convalescent villas, which kept the 'recoverable' at a greater distance from other patients. It has been argued that these units changed the dynamic of institutional treatment, through their strategic relocation to the boundaries of the asylum. At the same time that mental hospitals linked convalescents more clearly with those recently admitted from wider society, voluntary convalescence providers also began to expand their activities. Cottage homes, particularly those provided through the Mental After-Care Association (MACA: 1879), provided an additional locus for organised convalescence. The expansion of these homes mirrored a comparable increase in mental hospital convalescent villas after 1919. This chapter seeks to explain the reasons for this growth in voluntary convalescent services, and the role they served as an extension (and increasingly, alternative) to the convalescence provided within dedicated mental hospital villas.

As Mary Fisher has suggested, historians of nineteenth- and twentieth-century psychiatry have widely discounted the MACA's importance. However, those such as Andrew Scull and William Parry-Jones who have described the MACA as 'trivial' have tended to focus on the nineteenth century.

¹ Certainly, the charity continued to treat only a small proportion of cases discharged from mental hospitals, and later, of those admitted directly from the community. Yet as Fisher has noted, and as Chapter Four will explore in more detail, the impact of voluntary aftercare in the absence of many alternatives, may have had been considered as important by individual patients.² Moreover, the numbers treated for convalescence through the charity rose exponentially, as the present chapter explores, to more than 900 patients per annum by the late 1930s. At the time, authors such as Paul Winterton called for the MACA to extend so it could make its cottage homes available to all local authorities.³ It seems, therefore that Kathleen Jones's point that the charity's interwar aftercare work offered 'much hope for the future' was in some quarters keenly felt, to the extent that it was possible to envisage the charity fulfilling a national need for convalescence.⁴ Other historians have dismissed the charity's stance on cooperation as relatively conservative, compared with more recently established charities. Thus, while

¹ William Parry-Jones, 'The Model of the Geel Lunatic Colony and Its Influence on the Nineteenth-Century Asylum System in Britain', in Andrew Scull (ed.), *Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era* (Philadelphia, PA: University of Philadelphia Press, 1981), p. 212; Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (London and New Haven: Yale University Press, 1993), p. 321.

² Mary Fisher, "'Getting Out of the Asylum": Discharge and Decarceration Issues in Asylum History' (unpublished PhD thesis, University of East Anglia, 2003), pp. 253-4.

³ Paul Winterton, *Mending Minds: The Truth about Our Mental Hospitals* (London: Peter Davies, 1938), pp. 173-4.

⁴ Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services from the Early Eighteenth Century to the 1990s* (London: Athlone, 1993), p. 103.

Madeline Rooff has claimed the MACA's refusal to merge with other charities in the 1930s resulted from a backward-looking 'Victorian ancestry', Mathew Thomson has similarly perceived it as rooted in 'nineteenth-century voluntarism'.⁵ Changing focus to the MACA's stable relationship with the LCC, however, it appears the charity proved willing to continually adapt its approach to convalescence, in line with the authority's modernising focus. These elements of growth and service expansion are explored further in this chapter.

The MACA, and to a lesser extent other local charities, therefore helped shape the definition and practice of mental convalescence in England after 1919. They helped redefine its significance, in dialogue with the matrons who ran cottage homes and local authorities such as the LCC that increasingly subsidised them. Consequently, this chapter extends the focus on convalescence outside the mental hospital and into a community setting, but simultaneously considers how this may have served as an approved adjunct to hospitalised convalescence. While this chapter also considers other local initiatives in voluntary convalescence, as with Chapter Two, it nevertheless focuses particularly on the case of the LCC. Madeline Rooff and Kathleen Jones have especially identified the closeness of the relationship between the LCC and the MACA.⁶ As with the interwar convalescent villa explored in the last chapter, the present chapter will suggest the LCC performed a central role in the emergence of new forms of

⁵ Madeline Rooff, *Voluntary Societies and Social Policy* (London: Routledge and Kegan Paul, 1957), p. 119; Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Social Democracy, and Social Policy in Britain, c.1870-1959* (Oxford and New York: Oxford University Press, 1992), p. 177.

⁶ Rooff, *Voluntary Societies and Social Policy*, pp. 23-4, 116-9; Jones, *Asylums and After*, p. 128; Kathleen Jones, *Mental Health and Social Policy, 1845-1959* (London: Routledge and Kegan Paul, 1960), p. 106.

voluntary convalescent care in this period, centred on the cottage home. The shared personnel, financial arrangements, and discussions between these two bodies were notably close, while the LCC's asylums benefited particularly from the services the MACA provided. Of those providing convalescence through the MACA in selected years between 1918 and 1924, for which a hospital or clinic of origin was noted, over half (51.7 per cent) were referred from an LCC mental hospital.⁷ The LCC therefore proved central to the development and use not only of convalescent villas, but also community-based approaches to convalescence. At the same time, it is important to consider the broader context of convalescent services in the interwar period, as other charities and regions in certain cases developed independent residential services. Collectively, these charities helped further define the respective role of institutions and community in mental recovery.

2. Origins and New Directions: Voluntary Aftercare, 1871–1939

While Chapter One has suggested that late nineteenth-century asylums began to provide more home-like environments for a range of patients, the emergence of voluntary aftercare in this period more specifically targeted the convalescent patient. Henry Hawkins, the founder of the MACA, occupied a similarly liminal position between asylums and the community as the convalescent patients his charity sought to assist. As chaplain at London's Colney Hatch Asylum, Hawkins worked within the asylum system, and his

⁷ This is based on all entries relating to convalescents referred to MACA cottage homes in the years 1918, 1920, 1922, and 1924. In these years, 732 of 1,417 patients came from LCC asylums. Seven of these 732 patients were also admitted or readmitted in one of these years from a non-LCC mental hospital. Wellcome Library for the History and Understanding of Medicine [WLHUM], Mental After-Care Association [MACA], SA/MAC/G.2/3-5, Agenda Case Books, 1918-1924.

case for aftercare was repeatedly set before alienists in the *Journal of Mental Science (JMS)*; yet he also wrote and gave sermons to a wider Christian public. The holism of Hawkins's conception of recovery in *Made Whole* (1871), which linked spiritual, physical and mental determinants of mental health, echoed the more broadly 'moral' approach that Louis Charland has argued had earlier defined Tukean moral therapy.⁸ Among those behavioural adjustments patients might make to avoid relapse, Hawkins recommended participation in private and congregational worship, a balance between work and rest, and an airy and pleasantly decorated home.⁹ Like the Tuke's earlier Quaker interpretation of recovery, such advice suggested that convalescence could not be bounded by the asylum, but must instead necessarily continue into the community, in all aspects of the patient's life. Indeed, the publication of *Made Whole* through the Society for the Promotion of Christian Knowledge, represented convalescence as at least partially a form of self-help, and addressed the patient themselves, rather than the alienist.

Hawkins also directed his campaign for voluntary convalescence at alienists, and through his arguments sought to persuade them that it could form an integral part of the asylum system. Andrew Scull has counted the MACA among the 'critics of asylumdom', yet this obscures the extent to which Hawkins and the Association actively courted psychiatric support.¹⁰ Hawkins argued in 1871 that cottage homes represented an 'intermediate abode' between health-restoring institutional treatment, and potentially

⁸ Louis Charland, 'Benevolent Theory: Moral Therapy at the York Retreat', *History of Psychiatry* **18** (March 2007), p. 68.

⁹ Henry Hawkins, *Made Whole: A Parting Address to Convalescents on Leaving an Asylum* (London: Society for Promoting Christian Knowledge, 1871).

¹⁰ Scull, *Solitary Afflictions*, p. 321.

harmful social conditions.¹¹ As such, Hawkins envisaged the MACA as a stepping stone between the regenerative asylum and the degenerative slum, and as an ally of asylum psychiatry rather than an alternative. In a speech to the MACA's inaugural meeting, Hawkins told the assembled audience of alienists and philanthropists that the charity sought an 'alliance' with asylums, which would extend their protective function into the community.¹² Moreover, speeches and statements in the charity's early annual reports of the 1880s and 1890s broadcast the Council's view that support from asylum superintendents was 'wanting' and needed to increase to improve the charity's effectiveness.¹³ Far from criticising the asylum, Hawkins in his 1879 address praised its 'luxuries' and 'comforts', in contrast to the 'close murky room' and 'crowded court' he stated convalescents often returned to in London's East End. Whereas Scull has envisaged the MACA as part of a movement to challenge the 'warehouse' like late nineteenth-century asylum, Hawkins's speech suggested they might even offer a healthful reprieve to its impoverished East End inmates.¹⁴ Originally presented to a West End audience, Hawkins's paper arguably called upon the charity of his philanthropic audience to help fellow Londoners. Yet perhaps more importantly, it also offered reassurance to alienists present, or who read the subsequent article, that the MACA existed to remedy social rather than institutional failings.

¹¹ Henry Hawkins, 'A Plea for Convalescent Homes in Connection with Asylums for the Insane Poor', *Journal of Mental Science* **17** (April 1871), pp. 113, 116.

¹² Henry Hawkins, 'After Care', *Journal of Mental Science* **24** (October 1879), p. 363.

¹³ See for example: WLHUM, MACA, Annual Report of the MACA, 1888-9, p. 8, 1889-90, p. 4, and 1894, p. 7; WLHUM, MACA, Roxby, 'The After-Care Association for Poor Female Convalescents', p. 8.

¹⁴ Scull, *Solitary Afflictions*, p. 315.

Nevertheless, the membership of the MACA in its earliest years does suggest that its work remained relatively peripheral to mainstream alienism in the late nineteenth century. It is notable that of the three alienists present at the Association's first meeting, two (C. Lockhart Robertson and John Bucknill) had been amongst the few to experiment with boarding-out for convalescents in the 1850s and 1860s.¹⁵ The third, Daniel Hack Tuke, worked closely with Bucknill, most notably as co-author on their *Manual of Psychological Medicine*.¹⁶ Scull in particular has suggested that the MACA's activities corresponded with an often distinguished but largely atypical group of reformists.¹⁷ Henry Rayner was also amongst the MACA's earlier members as its chairman after 1895, and atypical of many alienists, due to his pioneering work with psychiatric out-patient treatment at St Thomas's Hospital (1889).¹⁸ In 1915 Rayner would testify to the charity's early ineffectuality in recruiting alienists' support, when he recorded appreciatively that asylum committees gave 'much more cordial help than in the earlier days of our existence'.¹⁹ While it is difficult to perceive the MACA as overt critics of asylumdom, it is possible to see its work as an implicit challenge to the ambitions of asylums as ostensibly curative institutions. Despite the credit Hawkins gave to asylums in recovery, he also argued that the public stigma of asylum treatment would make it 'more acceptable' to patients if

¹⁵ Susannah Strong, *Community Care in the Making: A History of the MACA, 1879-2000* (London: MACA, 2000), pp. 7-8. See also Chapter One.

¹⁶ Allan Beveridge, 'The Odd Couple: The Partnership of J.C. Bucknill and D.H. Tuke', *Psychiatric Bulletin of the Royal Society of Psychiatrists* **22** (1998), p. 52.

¹⁷ Scull, *Solitary Afflictions*, p. 321; Parry-Jones, 'Geel', p. 212; Douglas Bennett, 'The Drive towards the Community', in German E. Berrios and Hugh Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Gaskell, 1991), p. 323.

¹⁸ [Anon.,] *Henry Rayner, 1842-1926: Intimate Recollections* (London: Baines and Scarsbrook, c.1929), p. 49; Helen Boyle, 'Watchman, What of the Night?'. *Journal of Mental Science* **85** (September 1939), p.860.

¹⁹ 'The Mental After-Care Association', *Journal of Mental Science* **62** (April 1915), p. 324.

aftercare came through independent voluntary agencies.²⁰ Thus, although Hawkins had earlier called upon convalescents to show ‘gratitude’ to asylum physicians for their recoveries, he also suggested that public stigma (however misguided) and remoteness from working-class conditions (however therapeutic) inhibited asylums from participation in the final stages of convalescence.²¹

As more alienists became involved in the MACA’s work, it seems some at least sought to define its relationship with established asylum practice. In 1881, shortly after the charity’s foundation, Bucknill urged the MACA to restrict its help to ‘such convalescents as were thoroughly recovered’, on the basis of their readiness for domestic employment.²² Few records survive on the Association’s early approach to policy, but Bucknill’s intervention at least suggests that alienists may have sought to define its activities as social rather than medical, and therefore distinct from asylum practice.²³ Certainly, alienists engaged with what role the MACA should perform. Annual meetings provided a ‘sub-public’ arena for debate, as Vicky Long has argued, and to a limited but increasing extent allowed its members – including alienists – to contest understandings of the voluntary sector’s function in recovery.²⁴ Alienists who spoke at these meetings emphasised the Association’s purpose in giving patients a ‘fresh start in life’, and thereby

²⁰ Hawkins, ‘After-Care’ [1879], pp. 362, 366.

²¹ Hawkins, *Made Whole*, pp. 4-5.

²² “‘After-Care’ Association”, *Journal of Mental Science* (October 1881), p. 477.

²³ The first constitution was formalised in 1886, and later amended (e.g., 1894, 1913) to allow the extension of the charity’s work. See Jennifer Smith, ‘Forging the “Missing Link”: The Significance of the Mental After Care Association Archive’, *History of Psychiatry* **8** (1997), p. 413.

²⁴ Vicky Long, ‘Changing Public Representations of Mental Illness in Britain, 1870-1970’ (unpublished PhD thesis, University of Warwick, 2004), p. 227.

highlighted the distinct social focus of the MACA's activity.²⁵ Like Bucknill, these speakers pointed to the differences between the medical responsibilities of asylums, and the social responsibilities of the MACA, even whilst they saw both as part of the same project of social restitution. The normality they projected contrasted with the stark discontinuities between institutional and social life *Hospital* envisaged in 1899, when it claimed the MACA filled a 'horrible chasm' between the asylum gates and freedom.²⁶ In contrast, George Savage (Superintendent, Bethlem) sought to downplay the 'gulf (too often exaggerated by popular prejudice) between "alienism" and the ordinary conditions of social life' into which the MACA intervened.²⁷ Asylum superintendents, therefore, reinterpreted the nature of the MACA's work from within, and presented it as an approved adjunct to institutional treatment.

What role alienists felt the MACA should play, however, remained in flux, and to some extent reflects a growing interest in prevention and early treatment in this period. Louise Westwood has located the origins of the out-patient movement in mental health to the c.1890–1900s, and this interest in early treatment and prevention found some reflection in the MACA's work.²⁸ Hawkins's particular concern for friendless females meant that it was only in 1894 that the charity began to accept men.²⁹ It is likely this decision partly reflected the experience of the charity's secretary, who in 1893 announced

²⁵ [Dr. Blandford,] 'After-Care Association', *Journal of Mental Science* **47** (April 1900), p. 395; Robert Jones, 'The After-Care Association for Befriending Persons Discharged from Asylums for the Insane', *Journal of Mental Science* **53** (July 1906), p. 624; Robert Jones, 'The Urgent Necessity of Helping Mental Convalescents', *Journal of Mental Science* **55** (July 1909), p. 416.

²⁶ WLHUM, MACA, SA/MAC/H.2/2, Newspaper Cuttings, 'The After-Care Association', *Hospital* (February 1899).

²⁷ [G.H. Savage, cited in:] 'After-Care Association', *Journal of Mental Science* **47** (April 1900), p. 396.

²⁸ Louise Westwood, 'Avoiding the Asylum: Pioneering Work in Mental Health Care, 1890–1939' (unpublished PhD thesis: University of Sussex, 1999), p. 154.

²⁹ Hawkins, 'After-Care' [1879], pp. 358-9.

he had only rarely encountered friendlessness amongst convalescents.³⁰ But it is also possible that it stemmed from Henry Rayner's experiences, which were in turn perhaps derived from his experiences at the out-patient department he established at St Thomas's Hospital in 1889. Two years later in 1891, Rayner had made a case for a male aftercare charity, to help those otherwise in most danger of relapses from dangerous or taxing occupations. These comments provided a case for male aftercare, which betrayed foreknowledge of specific social attributions of mental illness, such as he may have encountered at St Thomas's. In the 1900s, Robert Jones (Superintendent, Claybury) set out a more clearly preventive case for mental aftercare. Pamela Michael has noted the hereditarianism in Jones's thought, and later involvement with the mental hygiene movement.³¹ These are both foreshadowed in his desire in 1906 that the MACA might propagate prophylactic advice, and 'engender a "hygienic conscience"' amongst the public.³² In turn, Jones in 1909 reflected that aftercare helped prevent 'continuing and permanent mental weakness', and as such constituted the final stage of treatment, and first defence against mental disorder, within a cyclical continuum of intervention.³³

At the other end of treatment, Hubert Bond in his 1913 paper to the Association considered ways to involve the MACA in the formal processes of asylum discharge for patients on trial. Whereas Jones had argued that the

³⁰ WLHUM, MACA, SA/MAC/A.1/2, H. Thornhill Roxby, 'The After-Care Association for Poor Female Convalescents on Leaving the Asylum for the Insane', speech, c.1893, p. 3.

³¹ Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800–2000* (Cardiff: University of Wales Press, 2003), p. 106.

³² Robert Jones, 'The After-Care Association for Befriending Persons Discharged from Asylums for the Insane', *Journal of Mental Science* **53** (July 1906), p. 625.

³³ Robert Jones, 'The Urgent Necessity of Helping Mental Convalescents', *Journal of Mental Science* **55** (July 1909), p. 416.

MACA should extend its role in prevention, Bond now proposed that at the other end, the charity should take those provisionally discharged from asylums on trial. Historians have indicated the longevity of trial as an asylum practice that dated back to at least to the 1830s.³⁴ It is significant, therefore, that it was only after 1913 that the MACA formally revoked an earlier resolution John Bucknill had supported, which debarred trial patients from assistance.³⁵ Steven Cherry and Mary Fisher have suggested superintendents practised parole and probation, as a means to free up hospital beds.³⁶ Bond's paper, however, suggests that for trial at least, superintendents' support for its extension resulted to some extent from medical rather than managerial rationales, centred on an emergent interest in early treatment. The causes of relapse Bond raised in his paper, such as malnutrition and occupational anxiety, raised specific therapeutic issues, relevant to the convalescent on trial, rather than the asylums to which they belonged.³⁷ An interest in prevention therefore appears to have motivated trained superintendents like Bond and Jones in the 1900–10s to promote an extension of convalescence into the community, at the same time that it encouraged contemporaries in the LCC to connect early treatment and convalescence within mental hospitals. Perceiving 'no sharp line between

³⁴ Leonard Smith, "'Your Very Thankful Inmate': Discovering the Patients of an Early County Lunatic Asylum", *Social History of Medicine* **21** (September 2008), pp. 240, 246-7

³⁵ "'After-Care" Anniversary', *Journal of Mental Science* **30** (October 1885), p. 448.

³⁶ Steven Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996), pp. 311, 313; Fisher, 'Getting Out of the Asylum', p. 202.

³⁷ Hubert Bond, 'After-Care in Cases of Mental Disorder, and the Desirability of its More Extended Scope', *Journal of Mental Science* **60** (April 1913), pp. 274-6.

stable recovery and unstable convalescence', Bond opened the door for the MACA to participate more closely in preventive medicine.³⁸

The discussion that followed Bond's paper suggests that unlike the previous generation of superintendents, most now supported an extension of the MACA's activities to the convalescence of trial patients. Four superintendents supported the proposal, with the recorded reservations restricted to potential difficulties of funding. Only Percy Smith (Medical Superintendent, Bethlem) raised a principled objection, arguing that convalescents should remain under psychiatric supervision in homes provided through asylums.³⁹ Bond concurred with Smith on the value of convalescent villas but nevertheless also felt that they could 'in no way... take the place of a period "on trial" spent in an environment entirely unconnected with the asylum'.⁴⁰ Involvement of the MACA in trial presupposed greater integration between psychiatric and voluntary agencies, directly challenging Smith's assumption that asylums should – or even could – take full responsibility for 'curing' patients. Bond's suggestion implied that medical recovery should be at least partially detached from asylum management, and delegated instead to the voluntary sector. The proportion of superintendent respondents to Bond's paper also indicates the extent to which the MACA offered psychiatrists a forum for discussion, and an arena for ongoing participation in decisions on patient treatment after discharge.

Superintendents monopolised eight of the nine places on the Sub-Committee

³⁸ See Chapters One and Two. Both Hubert Bond (Superintendent, Long Grove, 1907-1912) and Robert Jones (Superintendent, Claybury, 1893-1916) worked at LCC asylums at the time when this local authority began to extend admission hospitals and convalescent villas to its new asylums. *Ibid.*, pp. 280-1.

³⁹ *Ibid.*, pp. 283-4. Those that supported Bond's proposal were Sir James (Dr) Moody, Dr. J.R. Lord, Dr. Henry Rayner, and Dr. Cedric Bower.

⁴⁰ *Ibid.*, p. 286.

that subsequently approved Bond's proposal.⁴¹ This suggests that asylum staffs may have encouraged the delegation of trial cases to a charity in which they themselves took an active part. Charities such as the MACA arguably presented an additional site for psychiatrists to colonise outside asylums, alongside the home and out-patient clinics that Andrew Scull has claimed allowed them to 'expand their practice' into new spheres from the 1910s.⁴²

Addition of trial patients to the MACA's caseload redefined the relationship of convalescents to the community, and the responsibilities of voluntary and local authority sectors in supporting their recoveries. Previously, the Association's title referred simply to 'convalescents'; a label/category which Hawkins had applied to those who had *already* attained a psychiatrically 'convalescent' condition, but risked relapse through social pressures.⁴³ Hawkins in the 1870s had consequently equated psychiatric recovery with institutional discharge, and viewed the voluntary sector's input in convalescence as restricted to the preservation of health restored during asylum treatment.⁴⁴ The MACA trial Sub-Committee's decision in 1913 to change the Association's name to distinguish its work with 'convalescents' from patients 'recovered from asylums' suggested that the Association would now actively facilitate convalescence. The Sub-Committee's differentiation between the recovered, and convalescents that had not 'technically' been discharged, tacitly asserted the primacy of the psychiatric observation that the majority of the Sub-Committee practised in their professional lives as

⁴¹ 'The After-Care Association', *Journal of Mental Science* 61 (April 1914), p. 343.

⁴² Andrew Scull, 'Psychiatry and Social Control in the Nineteenth and Twentieth Centuries', *Social History of Medicine* 2 (1991), pp. 162-5; Andrew Scull, *The Insanity of Place, the Place of Insanity: Essays on the History of Psychiatry* (London and New York: Routledge, 2006), p. 29.

⁴³ Hawkins, 'After-Care' [1879], pp. 358, 360.

⁴⁴ See especially Hawkins, *Made Whole*, pp. 3-5.

asylum superintendents.⁴⁵ The Board of Control endorsed this interpretation of convalescence in 1924, when it noted that the MACA's introduction of support for trial cases had meant it 'no longer restricts its aid... but is freely willing to assist convalescing patients'.⁴⁶ Yet the MACA's new involvement in trial also reinforced the idea that convalescence was necessarily – if only partially – a social process. Jones (1909) and Roxby's (1911) papers given at earlier MACA annual meetings had already suggested that recuperation spanned institution and community, arguing that the Association existed partly to help complete (not just confirm) recovery.⁴⁷ Such ideas were tacitly recognised in the extension of the MACA's responsibilities to certified patients, making it easier to claim that its charity did more than merely maintaining health restored during institutional treatment.

Throughout the early twentieth century, mental patients had access to only a tiny proportion of the charitable convalescent homes available to those available for patients recuperating from physical illness. The Charity Organisation enumerated 240 general convalescent homes in the early 1890s, yet the *Hospital* recorded that the only homes available to mental patients were provided through the MACA.⁴⁸ These numbered between c.10–12 homes at points in 1905 and 1919, representing a tiny fraction of all homes. The situation had changed remarkably little in 1930 and 1931 when Elizabeth Gardiner's study of British convalescent homes found only four

⁴⁵ WLHUM, MACA, SA/MAC/C.2/1/1-3, Council Minute Books, Report of Sub-Committee, 15 May 1913, p. 2; 13 June 1913, p. 1.

⁴⁶ BoC Annual Report, 1924, p. 29. See also: Louise Westwood, 'Care in the Community of the Mentally Disordered: The Case of the Guardianship Society, 1900-1939', *Social History of Medicine* 20:1 (2007), p. 64.

⁴⁷ Jones, 'The Urgent Necessity', p. 411; WLHUM, MACA, SA/MAC/A.1/4/5, H. Thornhill Roxby, 'Provision of After-Care for the Recovered Insane' (paper read at the National Conference on the Prevention of Destitution), 1911, p. 3.

⁴⁸ WLHUM, MACA, Scrapbooks, [No Title], *Daily News* (8 June 1892), p. 5.

specific to mental and neurological disorders among 431 institutions studied.⁴⁹ Nursing home directories suggest that in 1934 there were actually at least sixty private homes taking 'mental', 'nerve', or 'neurasthenic' cases across England, but it is likely that most if not all catered only for paying patients.⁵⁰ Both surveys appear to have omitted the MACA's residential provision for rate-assisted cases, though the Association itself selectively compared its homes with the convalescent homes 'provided for the richer classes who are treated in... registered hospitals and licensed houses'.⁵¹ Although representing only a tiny fraction of the homes available to either private or general patients, the MACA had nevertheless doubled the number of homes on its books to a relatively stable 20 to 23 homes between c.1928 and 1939.⁵² This indicates that the MACA's convalescent home provision grew relatively rapidly in the immediate post-war era, potentially to meet the increased demand created by trial and early care. Furthermore, it suggests that compared with the incremental addition of mental hospital convalescent villas, the absence of similar capital costs or planning approval enabled the voluntary sector to respond relatively quickly to need.

Diversification in the MACA's activities accelerated during the 1920s and 1930s, with the addition of new services for ex-servicemen, early care and pre-care cases, and ongoing mental hospital residents.⁵³ Some of these

⁴⁹ Elizabeth Greene Gardiner, *Convalescent Care in Great Britain* (Chicago: University of Chicago Press, 1935), pp. 4, 62.

⁵⁰ *Nursing Homes 1934: A Directory of Nursing and Convalescent Homes, Mental Homes etc...* (London: Benn Brothers Ltd, 1934, 4th edition).

⁵¹ WLHUM, MACA, SA/MAC/H.2/1, Publicity and Information Sheets, [no title,] c.1938.

⁵² 'After-care for Voluntary or Temporary Patients', *BMJ* (22 August 1931), p. 356; WLHUM, MACA, Annual Report, 1935, p. 3; *The Voluntary Mental Health Services: The Report of the Feversham Committee* (London: Feversham Committee, 1939), p. 2.

⁵³ Jones, *Mental Health and Social Policy*, pp. 103, 106; Long, 'Changing Public Representations', p. 230.

new directions, such as the enlargement of charity to cover early care (1924) and the boarding of mental hospital patients in the community (1928), had been raised in Robert Jones's pre-war proposals for a 'further programme for the After-Care Association'.⁵⁴ As early as 1885, the MACA's Council contemplated the possibility that 'mental homes might do "preventive" service', indicating that members had long considered prevention a viable part of the charity's work.⁵⁵ Sir John Batty Tuke's pressure for lunacy reform to strengthen the practice of early treatment and aftercare in 1904 similarly pre-empted a more widespread recognition of the interconnectedness of prevention and convalescence in the interwar period.⁵⁶ Care for incipient and uncertified patients finally commenced in 1924, extending the MACA's interests over patients at a much earlier stage of treatment. Three homes reserved specifically for early care cases were opened shortly afterwards near London (1928) and further homes approved for 'pre-care' voluntary and temporary patients in summer 1931.⁵⁷ Early- and pre-care patients typically came to the Association from out-patient clinics and general hospitals, bypassing the asylum altogether and creating an entirely community-based trajectory for early treatment.⁵⁸ Annual reports consistently described the MACA involvement with these uncertified patients as 'convalescence', which resultantly implied a comparison between these patients, and regular

⁵⁴ WLHUM, MACA, Publicity and Information Sheets, 'The Mental After-Care Association', c. 1940-55, p. 5; Long, 'Changing Public Representations', pp. 181-2.

⁵⁵ "'After-Care Anniversary', *Journal of Mental Science* **30** (October 1885), p. 448.

⁵⁶ WLHUM, MACA, Scrapbooks, SA/MAC/H.1/3, 'The After-Care Association', *Lancet*, 1904; 'The After-Care Association', *Lancet* (27 February 1904), 588-9.

⁵⁷ London Metropolitan Archives [LMA], London Country Council, Mental Hospital Committee, LCC/MIN/756, Minutes of Special Sub-Committees, Letter from Ethel Vickers (Secretary, MACA) to LCC General Purposes Sub-Committee (quoted in minutes), 1 May 1931, 23 June 1931, pp. 234-5, 537.

⁵⁸ [Maurice Craig], 'Mental After Care Association. Prince George at Jubilee Meeting', *The Times* (Thursday 3 June 1930), p. 13, col. C; MACA Annual Report, 1924, p. 4; MACA Annual Report, 1931, p. 4.

'convalescents' discharged from mental hospitals.⁵⁹ The Association's notions of its role in both prevention and convalescence consequently expanded in the interwar era, as these areas became more closely entwined in new areas of voluntary practice.

A connection between convalescence and prevention had therefore already become manifest in the MACA prior to the First World War. Even so, shellshock and military psychoses appears to have impacted significantly on the MACA's approach to convalescence. During April and May 1917, the MACA paid close attention to the work of the Recuperative Hostels Committee, which was chaired by one of their own vice-presidents, Frederick Milner. Milner's claim that there were ex-servicemen 'even now waiting in asylums to be rescued', suggested at the least that such cases would not benefit from institutionalisation; more than this, it hinted that the health of the 'unnerved' would be best promoted in the community. The MACA's copy of Milner's article is circled in red ink, which suggests the charity may have drawn some inspiration from the Committee's work, or at least reflected on it in the light of its own activities.⁶⁰ Indeed, it was around this time that that the MACA began to admit shell-shock and air-raid casualties into its convalescent homes.⁶¹ During the rest of the war, the charity handled 91 ex-service cases, which represented a significant number in itself, and the start

⁵⁹ MACA Annual Report, 1924, p. 4; MACA Annual Report, 1933, pp. 3-4; MACA Annual Report, 1934, p. 3; MACA Annual Report, 1937, p. 3.

⁶⁰ WLHUM, MACA, Newspaper Cuttings, [Sir Frederick Milner, quoted in:] 'First Hostel for Heroes Opened', *Daily Graphic*, 16 May 1916.

⁶¹ MACA Annual Report, 1917, p. 3; WLHUM, MACA, SA/MAC/H.1/4, Scrapbooks, 'For Mental Cases. Care of Shell Shock Patients', *Christian World* (20 March 1919); WLHUM, MACA, 'Rough but Detailed Notes from Four Scrap-Books', p. 22.

of support for convalescents outside the asylum.⁶² From July 1923, the MACA entered into a formal agreement with the Ministry of Pensions (MoP) to provide aftercare for ex-servicemen discharged from the Ministry's south-coast rehabilitation centres. Consequently, the war provided the impetus that led to the MACA working for the first time with patients who had never entered the asylum. Its work with war victims tacitly recognised the potential benefit of convalescent care for those who had remained outside the mental hospital system, in the wider community.

The support the MACA gave to ex-servicemen from c.1917 represented a reappraisal of what might count as 'convalescence', and what role the voluntary sector might perform. Ena Elsey has indicated that the MoP's 'lavish promises' for a variety of rehabilitative and convalescent services for ex-servicemen encountered delays, whilst Peter Leese has shown that even where available, many remained short-staffed.⁶³ In this light, the MACA and other voluntary organisations, such as the Ex-Services Mental Welfare Society (1919), provided a useful service to official bodies unable to cope with the scale of demand. It is therefore possible to perceive the voluntary sector as a facilitator of new approaches to treatment beyond the asylum, alongside institutions such as the Cassel (1919) and Maudsley (1923), and clinics such as the Tavistock. Mathew Thomson and Louise Westwood have both indicated the extent to which those outside the mental hospital system contributed to the gradual development of community-based

⁶² MACA Annual Report, 1920, p. 4; Roof, *Voluntary Societies and Social Policy*, Tables 1-2, 'Number of Cases (Mental Illness) who were "Dealt with" by the M.A.C.A., 1887-1939', pp. 96-7, 119.

⁶³ Ena Elsey, 'The Rehabilitation and Employment of Disabled Ex-Servicemen after Two World Wars' (unpublished PhD thesis, University of Teeside, 1994), p. 29; Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (Basingstoke: Palgrave Macmillan, 2002), p. 143.

mental treatment services in the first decades of the twentieth century.⁶⁴ The MACA's involvement in convalescing neurasthenic ex-servicemen, and from 1924 early-care civilians, similarly appears to have followed on from a pre-war interest in pre-empting the causes of mental illness within the community. The shellshock episode provided a catalyst for these developments, particularly through the useful publicity it provided for the MACA, which repeatedly raised its involvement with ex-servicemen to its supporters. In its annual report for 1920, the MACA's Council expressed its hope that the help given to war victims would 'be an additional basis of appeal for assistance to the funds'.⁶⁵ At annual meetings, and in publicity sheets, the MACA similarly drew the attention of those with any interest in its work to the contribution it had made during the war.⁶⁶

The increasing emphasis placed on community-based treatment prior to hospitalisation is encapsulated in the Association's description of the treatment of early care patient 33151. Her case was represented in 1937 as that of a 'tired little war widow', whose problems stemmed from financial worries, and whose recovery to 'self-reliance', the MACA claimed, resulted from a four-week stay in one of its homes. The report identified the causes of the patient's mental fragility in the problems of wartime bereavement, and subsequent difficulties in civilian life making ends meet. It appears in this case that the MACA considered mental illness a logical outcome of

⁶⁴ Mathew Thomson, 'Constituting Citizenship: Mental Deficiency, Mental Health and Human Rights in Interwar Britain', in Christopher Lawrence and Anna K. Mayer (eds), *Regenerating England: Science, Medicine and Culture in Inter-War England* (Amsterdam and Atlanta, GA: Rodopi, 2000), p. 241; Louise Westwood, 'Avoiding the Asylum: Pioneering Work in Mental Health Care, 1890-1939' (unpublished PhD thesis: University of Sussex, 1999).

⁶⁵ WLHUM, MACA, Annual Report, 1920, p. 4.

⁶⁶ 'Shell-Shock Treatment', *The Times* (Thursday 13 March 1919), **42047**, p. 15, col. F; WLHUM, MACA, SA/MAC/H.1/2-5, Press Cuttings from Albums, 1897-1965, 'For Mental Cases: Care of Shell Shock Patients', *Christian World* (20 March 1919).

circumstantial social pressures, and cottage home convalescence the means by which such a patient might be restored to a state of lasting psychic equilibrium.⁶⁷ Psychiatrists increasingly expanded the concept of mental disorder in the interwar era, Andrew Scull has argued, to cover socially maladjusted delinquents, dependents, and neurotics.⁶⁸ It appears from the MACA's reports that the same period witnessed a comparable broadening of the concept of convalescence to encompass precisely such pre-acute borderline cases. Worried widows such as case 33151, unconfident elderly gentlemen (33134) and 'very difficult' girls (23525) sent to the MACA's convalescent homes during the 1930s exemplified the nervousness and delinquency that Scull has argued increasingly preoccupied interwar psychiatrists.⁶⁹ Whereas the MACA's trial sub-committee in 1913 had conflated convalescence with mental hospital treatment, early care introduced a more inclusive and socially-situated interpretation of convalescence. The MACA's Council minutes in 1939 referred to the beneficiaries of its early treatment as 'early care convalescents'. This linked prevention and recuperation in a similar way to paired admission and convalescent villas inside mental hospitals.⁷⁰ Charity publicity during the 1930s, however, also described the process of transfer of these cases from the private sphere into the charity's 'convalescent homes'.⁷¹ This presupposed that convalescence could occur entirely outside the mental

⁶⁷ WLHUM, MACA, *Annual Report*, 1937, p. 13.

⁶⁸ Scull, 'Psychiatry and Social Control', p. 165.

⁶⁹ WLHUM, MACA, *Annual Report*, 1933, p. 13; MACA, *Annual Report*, 1937, p. 12.

⁷⁰ WLHUM, MACA, Council Minutes, 6 March 1939.

⁷¹ WLHUM, MACA, *Annual Report*, 1933, pp. 3-4; MACA Publicity and Information Sheets, [untitled], c. 1938.

hospital system, amongst patients whose illness had never fully-developed into certifiable, hospitalised mental disorder.

The MACA's 1930 annual report accurately predicted the growing provision the charity would make for early care cases in the remainder of the decade.⁷² By the late 1930s, incipient and voluntary patients had come to occupy a substantial proportion of the Association's caseload. 'Convalesced' early care patients accounted for approximately one in every 11–14 patients helped in some way between 1936 and 1939, but a much higher proportion of those sent to cottage homes. More than one-third of those provided with residential convalescence in the late 1930s had never been sent to a mental hospital (Figure 11). Before the First World War all the Association's beds had been reserved for previously-certified aftercare patients. On the eve of the Second World War these patients had fallen to just over half of all cases received into its homes (52.6 per cent), due to the impact of voluntary and early admissions on the profile of the charity's convalescents. These figures support the claims of a later MACA publicity sheet (c. 1940–55) that early care had been in 'insistent and ever increasing' demand since its inception in 1924.⁷³ To meet this need, the Association had provided several dedicated early care homes during the 1920–30s.⁷⁴ Indeed, it actively encouraged out-patient clinics to make more use of these services, asserting in 1933 that they had 'not as yet taken full advantage of the benefits offered by this

⁷² WLHUM, MACA, *Annual Report*, 1930, p. 4.

⁷³ WLHUM, MACA, *Publicity and Information Sheets*, n.d. [c. 1940–55], p. 5.

⁷⁴ New homes for early care cases, possibly amongst others, were found in 1934 (two homes), 1936 (Mrs Barney), and 1938 (Miss Spiers). WLHUM, MACA, *Annual Report*, 1934, p. 3; WLHUM, MACA, *Council Minutes*, 31 July 1936; WLHUM, MACA, SA/MAC/C.2/3/1-2, *Council Minute Resolutions*, 23 September 1938.

Association'.⁷⁵ Figure 11 also suggests provision of early care grew alongside a strong demand for the convalescence of aftercare patients. Aftercare itself remained a consistently important part of the Association's convalescent work, but was now accompanied by a concern for the rehabilitation of those with little if any extended contact with mental hospitals.

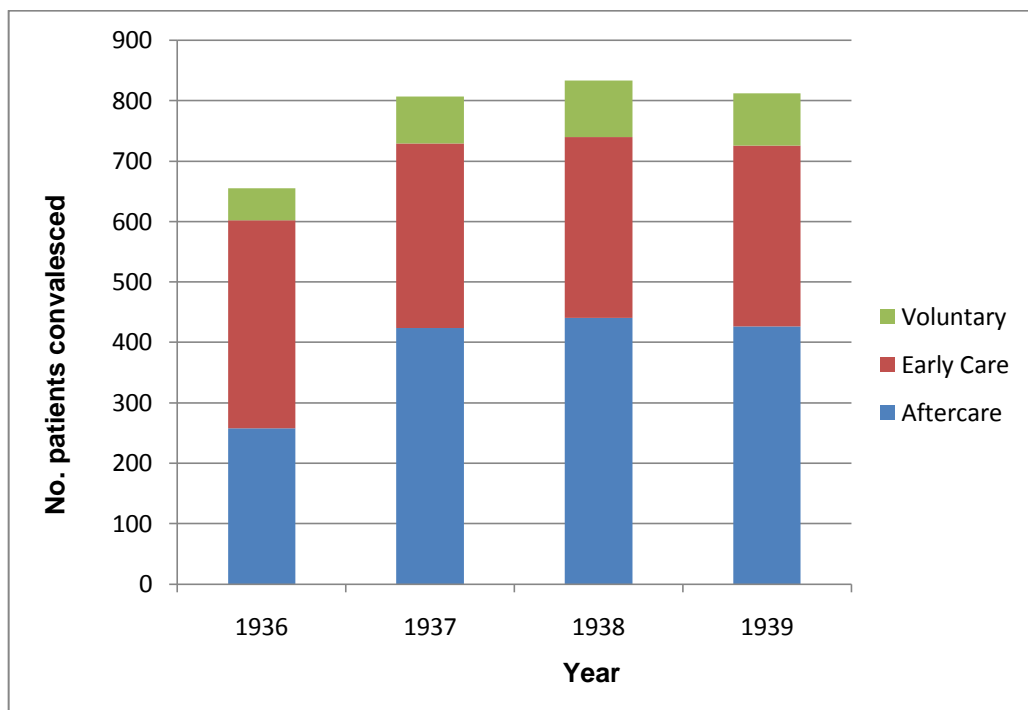


Figure 11: Types of Cases 'Convalesced' in the MACA's Cottage Homes, 1936–39.

Source: WLHUM, MACA, SA/MAC/B.1, Annual Reports.1936-39.

The work of other charities such as the Central Association for Mental Welfare (CAMW: 1913) and Guardianship Society [1913] increasingly encroached on the MACA's aftercare activities in the interwar period, even if they protested the uniqueness of their work. Originally called the Central Association for Mental Deficiency, the change to the CAMW in 1922 reflected

⁷⁵ WLHUM, MACA, Annual Report, 1933, p. 4.

the fact it had begun to assist mentally ill patients in 1921, in addition to its traditional work with the congenitally handicapped.⁷⁶ Most notably, in 1936 the CAMW opened the first two of its holiday homes for working mental hospital patients. The seaside location, intentionally homely atmosphere, and short-stay these homes provided closely resembled the sort of conditions the MACA promoted at its cottage homes for convalescents. Indeed, in 1938 the CAMW's Executive Committee directly compared them with 'ordinary holiday or convalescent home[s]' in a letter sent to *The Times*.⁷⁷ In 1937, the MACA trialled comparable holiday homes of its own, which it made available to chronic working patients at the LCC's asylums. It is possible, therefore, to trace an ever widening enlargement in the use of voluntary homes, from convalescents discharged from asylums 'recovered' (1880s), to convalescents discharged on trial (1910s), to convalescents that remained entirely outside the asylum (1920s), and finally to patients with little prospect of ever leaving the asylum (1930s).

As the MACA and CAMW diversified, and the differences between the charities narrowed, some felt it necessary to explain the role each served. E.M. Cemlyn Jones (County Council's Association), who reported on the CAMW's holiday homes for working patients at the Public Health Congress in 1936, suggested that the CAMW

Had no desire to trench upon the excellent work which the Mental After Care Association is doing for patients for whom a period of convalescence is desired immediately before and with a view to

⁷⁶ LMA, LCC, General Purposes Sub-Committee, LCC/MIN/696-701, Minutes, 28 March 1922; Roof, *Voluntary Societies and Social Policy*, p. 133.

⁷⁷ Leslie Scott, F. Douglas Turner and Evelyn Fox, 'Holiday Homes for Mental Patients', *The Times*, 16 September 1938, 48101, p. 8, col D.

discharge. The Central Association for Mental Welfare proposed only to deal with patients who would necessarily return to the mental hospital after their holiday⁷⁸

Jones, however, failed to recognise the coextensive spread of the MACA's work into areas such as early treatment, while he spoke before the charity also began to offer comparable holiday homes to those opened through the CAMW. Indeed, in a subsequent statement sent to the LCC'S Chief Officer, the MACA reacted testily to what they regarded as Jones's wrongful assertion that they dealt 'only with convalescent patients'. The MACA's response is significant, because it suggests that they regarded convalescence as one aspect of their temporary residential services by the late 1930s.⁷⁹ The MACA's subsequent decision to devise a comparable holiday home scheme for the LCC, and its earlier interest in Milner's Recuperative Hostels Committee, attests to the impact other initiatives taken within the voluntary sector had upon the charity's work. Publicity for the MACA's holiday homes placed in *The Times* in 1938 directly emulated earlier letters the CAMW had placed in the same newspaper, indicating the degree to which the activities of the two charities had begun to converge by this date.⁸⁰

In 1939, the MACA's Council would repudiate the idea that its activities overlapped with any other mental welfare charity. Nevertheless, in 1924–25 it had visited Brighton to help the Guardianship Society establish a local 'After-Care Committee', which subsequently performed comparable, if

⁷⁸ London Metropolitan Archives [LMA], London County Council, Mental Hospital Committee Presented Papers, LCC/MIN/607-660, Report by R.H. Curtis (Chief Officer, LCC Mental Hospitals Committee), 'Public Health Congress', 15 December 1936, p. 7.

⁷⁹ Ibid.

⁸⁰ WLHUM, MACA, Special Sub-Committee Minutes, n.d. (c.1930).

slightly different types of visitation and 'boarding-out' at Brighton Borough Mental Hospital. The Society tended to refer to 'boarding-out' rather than convalescence, and therefore hinted at its less transient involvement with patients.⁸¹ Louise Westwood has suggested the charity attempted to use boarding-out as a means to build long-term family relationships.⁸² This contrasted with the short stay of the MACA's convalescents in its cottage homes. While the MACA encouraged lasting familial feeling between patients and its matrons, therefore, its convalescence rarely extended to the sort of permanence the Guardianship Society attempted to foster. Even so, it became harder for the MACA to maintain the uniqueness of its aftercare work, given the Guardianship Society and CAMW's new activities. Locally, the MACA negotiated amicable working relationships with new CAMW branches at Portsmouth, Cambridge, and Worcester, which referred their mental convalescents to the Association.⁸³ Privately, however, the MACA's members complained in 1930 at the national CAMW's ambitions to centrally organise all social work, which the MACA's chairman felt belonged to his charity's area of expertise. Despite some convergence between these charities, it does appear, however, that the MACA's Committee was broadly right to see convalescence as an area that it maintained as its own.

It was at a more local level that other charities encroached on the sort of convalescence provided through the MACA, particularly in areas that had a strong independent tradition of voluntary action. The superintendent at

⁸¹ See for example: East Sussex Record Office [ESRO], Guardianship Society, GUA/1/1-3, 1913-38, General Committee Minutes, 12 October 1931, 17 July 1933, 18 October 1937, 19 April 1938.

⁸² Westwood, 'Care in the Community', p. 71.

⁸³ MACA Annual Report, 1927, pp. 11-4. See also: WLHUM, MACA, SA/MAC/H/5/11, Publications Produced by Other Bodies, proof of Central Association for Mental Welfare Annual Report, 1929, p. 9. Appendix 3 shows branches established by the MACA before 1925.

Fishponds Mental Hospital, Bristol, had previously only used the MACA's cottage homes, but in 1932 decided instead to utilise a convalescent home in Taunton run through the Bath and Bristol Mental Health Society (BBMHS). The availability of such a local society perhaps reflects the 'unusual extent' of voluntary services for mental patients that Graham Chester and Pamela Dale have identified in Somerset, and the high degree of cooperation Jan Walmsley (*et al.*) has uncovered between voluntary and local authority providers in this county.⁸⁴ The existence of this local Mental Health Society gave Bristol's superintendent an additional option for the practice of convalescence, which he apparently preferred because its location in Taunton was 'more convenient' than the MACA's homes.⁸⁵ While Fishponds continued to also send convalescents and money to the MACA into the late 1930s, the existence of the BBMHS allowed it to utilise more local convalescent services. Elsewhere, however, medical superintendents found they had fewer local options. Edwin Goodall at Cardiff City Mental Hospital complained in 1925 and 1926 at the absence of local cottage homes for South Wales. Like Bristol, Cardiff had previously used the MACA's cottage homes, but told the Macmillan Commission that this had proven so expensive 'we do not want any more of it'.⁸⁶ The following year, in a paper to

⁸⁴ Graham Chester and Pamela Dale, 'Institutional Care for the Mentally Defective, 1914-1948: Diversity as a Response to Individual Needs and an Indication of Lack of Policy Coherence', *Medical History* 51 (January 2007), pp. 60, 63; Jan Walmsley, 'Community Care and Mental Deficiency, 1913 to 1945', in Peter Bartlett and David Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London and New Brunswick, NJ: Athlone, 1999), p. 196.

⁸⁵ BRO, Bristol County Council, Mental Hospital Minutes, 3 October 1932, p. 116.

⁸⁶ *Minutes of Royal Commission on Lunacy*, Edwin Goodall (RMPA representative), interviewed 4 May 1925, p. 743.

the CAMW, Goodall again appealed to the 'great need for convalescent homes where such patients can go before returning to their ordinary work'.⁸⁷

The BoC's reports suggest that the BBMHS and Guardianship Society were local exceptions in a national system of aftercare dominated by the MACA. While the BoC and its commissioners commented on the work of both these charities, it placed most emphasis on the development of local branches of the MACA.⁸⁸ Louise Westwood has suggested that the Guardianship Society emerged at least partly from discussions between Helen Boyle and Grace Whitehead in the early twentieth century, which led to a sustained collaboration. These figures pioneered out-patient clinic care for early case at the Lady Chichester Hospital in Brighton.⁸⁹ It seems, therefore, that like Bristol, the development of local aftercare at Brighton benefited from a particular tradition of local outpatient services, which the Guardianship Society later in the 1920s extended to aftercare patients. While Goodall had by this date established a similar out-patient clinic in connection with Cardiff City Mental Hospital, his statements suggest he had fewer options for voluntary convalescence. As such, it appears that the MACA remained the dominant provider of voluntary convalescence outside a few localised hospitals that had access to proactive local voluntary action.

At the end of the 1930s, the MACA provided a broader range of services than at any other point in its existence. In a statement on inter-

⁸⁷ Edwin Goodall, 'Mental and Allied Disorders (Psychoses and Psycho-neuroses) from the Points of View of Scientific Investigation, Early Care and Treatment, and Education of Students', in *Report of a Conference on Mental Deficiency held at Central Hall, Westminster, London, S.W. on Thursday and Friday December 2nd and 3rd, 1926* (London: Central Association for Mental Welfare, c.1926-7), p. 71.

⁸⁸ BoC, *Annual Report*, 1932, p. 44; BoC, *Annual Report*, 1934, Bristol Mental Hospital, visited 15 March 1934, p. 351.

⁸⁹ Westwood, 'Avoiding the Asylum', pp. 71, 77; Westwood, 'Care in the Community'; Louise Westwood, 'A Quiet Revolution in Brighton: Dr Helen Boyle's Pioneering Approach to Mental Health Care, 1899-1939', *Social History of Medicine* **14** (December 2001), 439-57.

charity coordination sent to the Feversham Committee in 1938, the MACA itself acknowledged that it had adapted its activities over time to reflect a 'widened conception of what mental health means'.⁹⁰ It had successively broadened its recipients since the 1890s to include men (1894), convalescents within asylums (1913), convalescents whose treatment was wholly managed in the community (c.1917, 1924, 1928), and in a departure from rehabilitative support, chronic mental hospital patients (1937). Before 1921, the cover of the Association's annual reports claimed with some accuracy that its specialist concern with psychiatric convalescence made it the 'only charity of its kind in the United Kingdom'.⁹¹ After this date, however, the diversification of the MACA and other mental welfare charities made it more difficult to contend that they operated in isolation. The incursion of other charities into palliative care (e.g., CAMW), mental aftercare (e.g., Guardianship Society) and even mental convalescence (e.g., BBMHS) belied the claims the MACA again made to its uniqueness in 1938–39.⁹² Nevertheless, its increasingly inclusive approach to convalescence itself to some extent distinguished the MACA's contribution to mental welfare. During the 1920s and 1930s the MACA's admittance of early care and voluntary 'convalescents' into its cottage homes reinterpreted the idea of convalescence itself, as a phase of readjustment that could take place entirely in the community or with minimal contact with mental hospitals. So too, the extension of care to chronic patients suggested the temporary

⁹⁰ WLHUM, MACA, Council Minutes, statement of the Mental After-Care Association on the findings of the Feversham Committee (December 1938), 16 December 1938.

⁹¹ This claim last appeared on the cover of the MACA's annual report for 1920. WLHUM, MACA, Annual Report, 1890/1-1920.

⁹² WLHUM, MACA, Feversham Committee, Mental After-Care Association Papers, statement of the Mental After-Care Association on the findings of the Feversham Committee, December 1938, pp. 1-2.

respite provided through residential care could serve a palliative as well as recuperative function, benefiting those that have often been overlooked in medical histories.⁹³

3. Cottage Homes: Familial and Familiar Spaces for Healthcare?

Unlike the mental hospital convalescent villa examined in Chapter Two, the MACA's cottage homes were not purpose built, with the exception of a home at Redhill swiftly abandoned around c.1895.⁹⁴ The charity regularly advertised for matrons in the local and national press, and its ability to choose suitable homes was therefore limited according to the response it received. An indication of both the MACA's selectiveness, and its inability to control the homes offered for use, are indicated in a minute from 1918, which recorded that three such notices yielded 'only one [home]... likely to be suitable'. In other years, as in 1920, the Council evidently had more choice, when a similar appeal brought in a 'great many answers'.⁹⁵ While Lindsay Prior has suggested that architectural plans serve as 'archaeological records' of medical practices, this seems to apply less to the MACA's homes, which perhaps more accurately record only the location of those interested in helping the charity. While Prior suggests medical buildings can be 'read... for discursive themes', it is necessary in the case of the MACA's cottage homes

⁹³ Ian Miller, 'The Mind and Stomach at War: Stress and Abdominal Illness in Britain, c.1939-1945', *Medical History* **54** (January 2010), pp. 95-6.

⁹⁴ Henry Hawkins later claimed the home at Redhill had closed the same year it opened. Annual reports, however, indicate the home had opened on 16 March 1893, and later reported its closure in 1895. Smith, 'Forging the "Missing Link"', p. 415; Strong, *Community Care in the Making*, p. 12; Hawkins, 'Reminiscences', p. 304; WLHUM, MACA, Annual Report, 1892-3, p. 6, and 1895, p. 5.

⁹⁵ The latter upsurge in potential homes followed the appointment of a sub-committee in May 1920 specifically to find more cottage homes. WLHUM, MACA, Council Minutes, 4 April 1918, 25 April 1918, 20 May 1920, 29 July 1920.

to go beyond the buildings themselves, and as William Whyte has suggested, look instead at how those who utilised them for convalescence envisaged their function.⁹⁶ This section accordingly gauges how the MACA evaluated the suitability of its various cottage homes for the purpose of mental convalescence. Often these homes had an ephemeral life, lasting little longer than their patients' convalescence, as at Miss Winter's, which closed after just three months.⁹⁷ Others, however, were used for decades, such as Mrs Foster's, which opened in the 1920s and only shut in 1959 on account of the matron's advanced age.⁹⁸ What factors caused some homes to remain consistently on the MACA's books, whilst others vanished after just a few months?

As with convalescent villas within mental hospitals, administrative practicalities intruded upon and influenced the spatial organisation of convalescent accommodation. The MACA rejected and closed homes that it considered too inaccessible, in the case of Mrs Goodwin's home because experience had shown that 'the fare and distance were both so great'.⁹⁹ Mrs Careless was similarly informed that the Association would consider her home only so long as it was 'not too far away', indicating the degree to which accessibility informed the location of cottage homes.¹⁰⁰ Consequently, the charity sought to strike a balance between the desire to minimise financial and logistical impositions on the charity, and its therapeutic sensitivity to

⁹⁶ Lindsay Prior, 'The Architecture of the Hospital: A Study of Spatial Organization and Medical Knowledge', *British Journal of Sociology* **39** (March 1988), pp. 91, 93; William Whyte, 'How do Buildings Mean?: Some Issues of Interpretation in the History of Architecture', *History and Theory* **45** (May 2006), pp. 172-3.

⁹⁷ WLHUM, MACA, Council Minute Resolutions, June and September 1925.

⁹⁸ WLHUM, MACA, 1941-59, SA/MAC/F.1, Cottage Home Files: Mrs Foster, Miss Russell to Mrs E. Foster, 22 June 1959.

⁹⁹ WLHUM, MACA, Council Minutes, 25 November 1932.

¹⁰⁰ *Ibid*, 31 December 1931.

patients' need for a full 'change' of scene and environment. This tension between administrative practicalities and therapeutic goals is evident in R.C. Turnbull's (Medical Superintendent, Severalls) reflections on early care homes in 1930. Turnbull felt these homes should function as convalescent homes, and be 'within reasonable distance' but also 'where the patient would get a complete change'.¹⁰¹ Significantly, this interpreted 'complete change' in terms of a physical and spatial removal of patients from their former environment. It also, however, illustrates the practical logistical considerations that also constrained how far the MACA was able to freely select sites for convalescence on therapeutic grounds alone. The Association did occasionally justify its decisions on the retention of homes on the therapeutic benefit they could provide patients through their location. In May 1939 it planned the temporary closure of Mr Pym's cottage home during the following winter 'through the dullness only and desire for the seaside'.¹⁰² In most cases, however, the MACA is likely to have been constrained into compromise, so that while environment mattered in its vision of convalescence, it only exercised limited control over where convalescents were boarded.

Existing homes were nevertheless evaluated as sites of convalescence, particularly through regular unannounced home inspections.¹⁰³ Rather than attempting to 'read' a direct medical function from the spatial layout of cottage homes, it seems preferable as William Whyte has argued to 'translate... multiple transitions in their use. Drawing upon

¹⁰¹ WLHUM, MACA, Special Sub-Committee Minutes, [Dr Turnbull, cited in:] memorandum re coordination and training of social workers, n.d. [1930].

¹⁰² WLHUM, MACA, Council Minutes, 8 May 1939.

¹⁰³ WLHUM, MACA, Council Minutes.

contemporary discourse on their use, it becomes possible to create a layered interpretation of architects', inhabitants', and commentators' perspectives of their function.¹⁰⁴ These descriptions selectively emphasised particular aspects of domesticity, in ways that deconstructed and reinterpreted the unremarkable homeliness of these buildings for their therapeutic potential. At a basic level, the MACA in 1930 distinguished the 'atmosphere... of home' they provided, compared with 'that of an institution', thereby contrasting the quality of their domesticity with the wards and villas found in mental hospitals. This reflected a belief in the MACA that its homes afforded a more heightened sense of domesticity than could be achieved within institutions. A lack of signs on its homes, Ethel Vickers wrote in May 1931, meant 'they could be regarded in the light of boarding homes, and only we would know that they are under special care'.¹⁰⁵ As such, the privacy of these voluntary homes was interpreted as a means of avoiding institutional stigma. The LCC's Mental Treatment Sub-Committee interpreted the anonymity of the MACA's homes as a 'method of providing homes' wholly 'dissociated from institutionalism'.¹⁰⁶ In 1934 the MACA equated the 'absence of official machinery' with the 'homely, and friendly feeling' provided to patients.¹⁰⁷ The Association therefore took an explicitly comparative view of domesticity, which interpreted the benefits of its homes in contrast to the impersonal and stigmatised mental hospital and other forms of institutional treatment.

¹⁰⁴ Whyte, 'How do Buildings Mean?', pp. 153-5, 170-3.

¹⁰⁵ LMA, LCC, Mental Hospitals Committee, Minutes of Special Sub-Committees, Ethel Vickers to LCC General Purposes Committee, 1 May 1931, cited in minutes 18 June 1931, p. 235.

¹⁰⁶ LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee Minutes, Mental Treatment Act Sub-Committee report, 7 June and 18 June 1931, cited in minutes 23 June 1931, p. 537.

¹⁰⁷ WLHUM, MACA, *Annual Report*, 1934, p. 2.

With between one and eight convalescents per home in the 1930s, cottage homes remained considerably smaller than equivalent mental hospital accommodation. The average number of residents in 1928 stood at 5.7 patients, less than half the minimum number (12-30) the BoC had advised for mental hospital convalescent villas in 1924.¹⁰⁸ The Association's report for 1919 had argued that homes should ideally take no more than four patients each.¹⁰⁹ Mr Carapata's at Leigh-on-Sea contained twice this number in 1933, indicating some flexibility in the Association's approach to numbers, though not to the extent found in many hospital villas (see Chapter Two). It remained smaller than the smallest convalescent villas, and consequently a more domestically-scaled option for convalescent treatment. Minutes rarely note in any detail why certain houses may have been considered particularly suitable. The fragmentary evidence available does, however, suggest that physical scale may have formed part of the Council's assessment criteria when deciding upon homes' suitability. Mrs Foster originally took four male patients into her home in 1928, before moving to another house in the town during 1933. Commenting upon the new house, the Council drew particular attention to its size, which it felt 'large, very suitable and with a big garden... in every way suitable' [*sic*].¹¹⁰ Size proved an important consideration in the selection of homes, even if the Council discouraged extremes in their dimensions. Thus, while Mrs Ellis was advised to 'try for a smaller place' in

¹⁰⁸ LMA, King Edward's Hospital Fund for London, A/KE/316, Convalescent Home Grading, 'Particulars (1930) of Convalescent Homes not Attached to London Hospitals Applying for Grants in 1931', 1931, p. 2; WLHUM, MACA, Council Minutes, 1 August 1928; WLHUM, MACA, Council Minute Resolutions, 28 May 1931; BoC, *Annual Report*, 1924, p. 15.

¹⁰⁹ WLHUM, MACA, *Annual Report*, 1919, p. 5.

¹¹⁰ Miss Russell (MACA), who had visited this home upon its opening in 1928, reflected again upon the home's large size and grounds when Mrs Foster retired thirty-one years later. WLHUM, MACA, Council Minutes, 14 July 1933; WLHUM, MACA, Cottage Home Files: Mrs Foster, Miss Russell to Mrs E. Foster, 22 June 1959.

1928, Mrs Careless was told later the same year that the Association would consider sending more patients 'if she took a rather larger house not too far away'.¹¹¹

Interwar annual reports and surviving post-1940 inspection reports provide more detail on the MACA's priorities in home-management than the necessarily brief comments preserved in interwar minutes. These support the view that the Association may have evaluated the suitability of homes for convalescence primarily on their ability to supply patients with a happy and homely environment for recuperation. Interwar reports particularly emphasised the advantageous homeliness of this accommodation.¹¹² Later reports from 1941–43 formulaically concentrated upon similar themes, including the tidiness and cleanliness of homes, patients' happiness, and the quality and type of food made available. This directed attention to the internal appearance of homes rather than their location, and put a premium on domestic management according to inspectors' expectations of homeliness.¹¹³ As Chapter Four will explore, patients often represented their convalescence as a 'holiday'. In contrast, the MACA's concern with the standard of management of these homes seems to have stemmed from a concern to foster a model environment to protect and promote fragile recoveries. References to cleanliness, good diet and contentedness in the MACA's inspection reports reflected therapeutic concerns that aimed to provide a model domestic environment for impressionable patients. The

¹¹¹ Ibid., 9 May 1928, 31 December 1928.

¹¹² WLHUM, MACA, Annual Report, 1920, p. 4; WLHUM, MACA, Annual Report, 1925, p. 5; WLHUM, MACA, Annual Report, 1930, p. 5.

¹¹³ These themes were raised repeatedly in the cottage home reports of 'C.W.' in the early-1940s at Mrs Drew's, Mrs Abbott's, and Mrs Foster's homes. WLHUM, MACA, SA/MAC/F.1/1, 4, 6, Files on Individual Homes, 1940-62.

differences in expectations between patients and inspectors is perhaps exemplified in 'C.W.'s' critical comments on Mrs Abbott's decision to wear a dressing gown to serve breakfast, which they disapprovingly interpreted as evidence of her 'lateness' and evidence that she was 'not dressed'. The MACA'S concern for the effect this might have on convalescents – and the convalescents' unconcern – is evident in the charity inspector's comment that this 'appeared to make no difference to the men and their means'.¹¹⁴

It seems that a larger than average yet still homely and above all shared domestic environment were considered the most desirable features in cottage convalescent homes. In other cases, a warning that a proprietor should 'try to add to the comforts' of their home (1929), and the closure of another home due to the state of the beds (1927) indicate the importance attached to some degree of material comfort.¹¹⁵ Following a complaint about the food at one home, J.M. Oakey (Treasurer, MACA) felt the Council should investigate further should a similar objection arise in future.¹¹⁶ These brief comments indicate the continual interplay of patients', charity workers' and proprietors' concerns and expectations for the quality of care in convalescence. The views of others were also occasionally taken into consideration, such as Mr Ruck, an inspector of the local public assistance committee, and Richmond's board of guardians. Their opinions informed those of the Council, which chose to report both Ruck's favourable impressions, and investigate (and ultimately dismiss) Richmond's

¹¹⁴ WLHUM, MACA, Files on Individual Homes, Mrs Abbott's Home, 'C.W.', report on home, 5 February 1942.

¹¹⁵ Ibid., 29 September 1927, WLHUM, MACA, Council Minute Resolutions, 21 December 1929.

¹¹⁶ Ibid., 14 July 1933.

dissatisfaction with the proportion of relapses from Mrs Marsh's home.¹¹⁷ If the MACA counted the most successful homes as those that sustained an affinity between patients and matrons, the adverse comments of patients and other visitors could also contribute to their review or outright closure. In one case the comments of a medical superintendent sufficed to close a home (February 1920), while in others patients' comments and those of a local medical officer of health led to reviews and warnings (September 1920, 1936).¹¹⁸ The Association arbitrated over decision-making, yet took into account a variety of opinions on the quality of convalescent homes, even if it ultimately chose to ignore complaints or defer action until a later date.

Defined partly in antithesis to the institution, the MACA also represented its homes more positively as familial spaces with domestic attributes. Highlighting the importance of inclusive sociability to rehabilitation, the MACA's report for 1925 felt they functioned as 'homes in which the patient becomes part of a sympathetic and understanding family'.¹¹⁹ This supports Chris Philo's speculation that cottage systems may have been 'less about places than people', and that the relative lack of control the Association held over environment perhaps mattered less than decisions over who should run the homes.¹²⁰ The charity framed convalescence as a social problem from the outset in its initial focus on friendlessness as a cause of relapse. Interpersonal support remained a core function of cottage homes in the 1930s, even after the focus had shifted from the simple absence of

¹¹⁷ Ibid., 8 December 1933; WLHUM, MACA, Council Minutes, 18 July 1918.

¹¹⁸ WLHUM, MACA, Council Minutes, 26 February 1920, 10 July 1936; WLHUM, MACA, Council Minute Resolutions, 7 May 1925.

¹¹⁹ WLHUM, MACA, Annual Report, 1925, p. 5.

¹²⁰ Chris Philo, *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter, Ceredigion, and New York: Edwin Mellen Press, 2004), p. 612.

relationships onto patients' adaptation and correction of faulty relationships. Extracts from patient and family letters emphasised the kindness and sympathetic understanding received under care. The selective inclusion of these statements in the MACA's reports in the 1930s therefore drew attention to moral and interpersonal aspects of its convalescent treatment.¹²¹ To some extent, these benefits were again defined in opposition to other potential sites of care-giving. In its report for 1938, the MACA contrasted the supportive 'stepping-stone' of its cottage home treatment against the unsympathetic attitudes of the 'ordinary community'.¹²² This suggests that these homes were considered necessary in part due to defective relationships and societal prejudice in the wider community. At the same time, however, the MACA also defined the benefits of its homes more positively, particularly in the 'friendly feeling' and 'happy relations' that it felt existed between patients and homes, which pointed to a healthful affinity between staff and their patients.¹²³

For all their apparently recognisable homeliness and familial sociability, cottage homes represented artificial environments for recovery. The MACA and LCC each referred to the protection cottage homes afforded patients from 'a world of work and worry', which consequently suggested they offered an idyllic but synthetic simulation of domestic life.¹²⁴ As an intermediate step between institution and society, cottage homes belonged

¹²¹ E.g., WLHUM, MACA, Annual Report, 1931, p. 12, case 20072; WLHUM, MACA, Annual Report, p. 11, case 22920; WLHUM, MACA, Annual Report, 1936, pp. 10-11, case 31669.

¹²² WLHUM, MACA, *Annual Report*, 1938, p. 3.

¹²³ WLHUM, MACA, *Annual Report*, 1926, p. 4; WLHUM, MACA, *Annual Report*, 1939, pp. 4-5.

¹²⁴ LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee, report of Mental Treatment Act Sub-Committee of 12 February 1931, 17 February 1931, p. 446; WLHUM, MACA, Publicity and Information Sheets, n.d. [c.1938].

to neither, but rather provided a form of rehabilitative refuge to their inhabitants. Quiet, rest and 'change' all regularly featured in speeches and reports that elaborated on the use of these homes. These terms tacitly allude to correlative social pressures of noise and activity (including work) that cottage homes shielded from patients unprepared for unmediated community integration.¹²⁵ The MACA's 1937 report described them as a 'haven of rest', which underlined the relative absence of pressures and stresses that might impede recovery compared with life in the wider community.¹²⁶ These homes therefore offered a relatively neutral if unnatural alternative to the reintroduction of patients into mainstream society, manufactured to mediate the problematic discontinuities between institutional and community life. Indistinguishable from ordinary homes in their design, cottage homes derived their distinctiveness from their constructed routine and planned interpersonal relationships. The charity's publicity challenged the suitability of working-class conditions to mental health, both questioning the sensitivity and sympathy of the general public to mental convalescents, and benefit of the 'unsatisfactory home' to recovery.¹²⁷ In contrast to the social insensitivity it perceived amongst some parts of the wider public, the MACA represented its homes as places of nurture and support than helped 'succour', 'guide', and

¹²⁵ WLHUM, MACA, *Annual Report*, 1924, p. 8; [Prince George, cited in: 'Mental After Care Association: Prince George at Jubilee Meeting', *The Times* (Thursday 3 June 1930), p. 13, col. C; [Dr Turnbull, cited in:] WLHUM, MACA, memorandum on voluntary coordination and the training of social workers, n.d. [c.1930]; WLHUM, MACA, *Annual Report*, 1931, p. 4; WLHUM, MACA, *Annual Report*, 1933, p. 15; WLHUM, MACA, *Annual Report*, 1934, p. 15.

¹²⁶ Elsewhere, in 1930 the CAMW's journal *Mental Welfare* described them as 'intermediate or "neutral"' spaces 'as a preliminary to taking up the threads of normal life'. See WLHUM, MACA, *Annual Report*, 1937, p. 2; 'Mental After Care', *Mental Welfare* 11:2 (1930), p. 44.

¹²⁷ WLHUM, MACA, *Annual Report*, 1935, p. 3; WLHUM, MACA, *Annual Report*, 1938, p. 3; WLHUM, MACA, Publicity and Information Sheets, n.d. [c.1938].

'shepherd' convalescents back to health.¹²⁸ As such, cottage homes were paradoxically presented as *more* normal sites for the complete restitution of mental health than the community to which patients would ultimately return.

To some extent cottage homes provided a surrogate family environment, which separated patients from institutional and home conditions, and replaced this with an idealised model of secluded domesticity. Comparisons made in Hawkins's speeches and MACA newspaper cuttings after 1871 between cottage homes and 'ordinary life' and 'family life' suggest these homes had always been equated with recognisably social and normatively familial spaces.¹²⁹ A preference for married proprietors in adverts and resolutions passed in the 1900s, particularly for female convalescents, reinforces this impression.¹³⁰ The majority of homes were registered to married women between the wars, which therefore in most cases placed convalescence under female domestic management within a division of labour between husbands and wives.¹³¹ While this seems to have become less integral to the MACA's homes between the wars, male cottage home proprietors do seem to have routinely received male

¹²⁸ WLHUM, MACA, *Annual Report*, 1935, p. 3; [Sir Charles Wakefield, cited in:] 'Charity Meeting: The Mental After Care Association', *The Times* (Friday 30 March 1928), p. 9, col. F.

¹²⁹ Hawkins, 'A Plea for Convalescent Homes', p. 107; [Dr Saunders, cited in:] WLHUM, MACA, Newspaper Cuttings, [no title] c. 1886-1900; WLHUM, MACA, Newspaper Cuttings, [no title] 1901.

¹³⁰ WLHUM, MACA, Newspaper Cuttings, advert placed in *East Sussex Gazette*, 7 February 1902; WLHUM, MACA, Scrapbooks, 'Suggestions of the Sub-Committee on the Extension of the Work of the After Care Association', 9 March 1904, point 6; WLHUM, MACA, 'Rough But Detailed Notes', p. 16.

¹³¹ In extant council minutes and resolution books between April 1917–September 1920, September 1921–September 1939, 41 homes were registered under the name of married women, two more under the name of both wife and husband, 12 under unmarried women, and six under men. WLHUM, MACA, Council Minutes and Council Minute Resolutions.

convalescents.¹³² More important to the gendered construction of these homes, convalescents themselves were sometimes (perhaps always) grouped in homes according to their sex.¹³³ This replicated the divisions between men and women practised in most mental hospitals, and perhaps points to differences in how convalescence was viewed according to sex. The charity's case records suggest that consistently more than 70 per cent of all the MACA's convalescents between 1910 and 1928 were women.¹³⁴ This regularly exceeded the ratio of female discharges from county asylums, at between 55–60 per cent over the same period.¹³⁵ It seems, therefore, that convalescence remained a predominantly feminine practice several decades after the MACA opened its charity to men. Registers also indicate that the MACA often helped men obtain access to Rowton Houses, and it is possible that many men that might have received convalescence were referred instead to lodging houses such as these from the 1910s.¹³⁶

Admissions policies to the MACA's homes from the 1910s increasingly differentiated care according to convalescents' psychiatric background. Introduction of trial care in 1913 in particular raised a discussion over the need for specialisation in home management. At the outset, the

¹³² Ibid., 18 June 1925, 15 December 1926, WLHUM, MACA, Council Minutes, 9 July 1931, 10 July 1936, 28 May 1937.

¹³³ The BBMHS certainly provided its two homes according to the gender of patients. The evidence for the MACA, however, is based on Council minutes that refer to specific homes that took either men or women. WLHUM, MACA, Council Minutes, 15 December 1926, 28 May 1931, 9 July 1931, 29 May 1936, 28 May 1937; BRO, Bristol County Council, Mental Hospital Minutes, 3 October 1932, p. 116; BoC, Annual Report, 1935, Fishponds Mental Hospital, visited 15 March 1934, p. 341.

¹³⁴ This covers case registers for 1910, 1914, 1918, 1920, 1922, 1924; and Council Minutes for August and September 1928. WLHUM, MACA, SA/MAC/G.1-3, Agenda Case Books, 1910-24.; WLHUM, MACA, Council Minutes, 1 August and 12 September 1928.

¹³⁵ Board of Control, *Annual Reports*, 1910-1924, 1928.

¹³⁶ Rowton Houses provided affordable accommodation for working men in London, with five opened here between 1892 and 1905. George Orwell described their outward grandeur and closely-policed door policy in *Down and Out in Paris and London*. See George Orwell, *Down and Out in Paris and London* (London: Penguin, 2003 [1933]), p. 165.

Council focused on whether existing matrons might decline admittance to these certified cases. This question assumed that the same homes might take both aftercare and trial convalescents, and implied some willingness on the part of the Council to accept their dual management.¹³⁷ Rules sent to matrons in c.1914 assumed they would have some prior knowledge, and perhaps experience, in caring for aftercare patients. Nevertheless, Henry Rayner anticipated their reticence to take such cases would require a 'quite different kind of home', whilst instructions sent to matrons made the procedural differences clear.¹³⁸ These rules cautioned that trial patients 'have to be dealt with in a rather different way from cases discharged recovered', and matrons were accordingly instructed on their responsibilities for referral upon relapse and certification upon recovery.¹³⁹ By the 1930s, admission to homes depended upon the origins of the case (e.g., trial, early care, aftercare), and the patient's sex.¹⁴⁰ This broadly emulated the classificatory systems found in mental hospitals, which bisected patient populations into two gendered halves, and then distributed them into wards and blocks on the basis of their condition. Yet whereas mental hospitals tended to define patients according to prognosis (e.g., acute, chronic, convalescent), voluntary cottage homes clustered convalescents according to their past case history. Cottage homes consequently provided an inverse mirror image of institutional classification. Their designation for recovered, probationary, or early-care cases memorialised patients' pathway to treatment, rather than

¹³⁷ WLHUM, MACA, Council Minutes, memorandum re trial cases, 15 May 1913, p. 2.

¹³⁸ [Henry Rayner, cited in:] 'After-Care in Cases of Mental Disorder', p. 284.

¹³⁹ WLHUM, MACA, SA/MAC/C.4/4, Propaganda Committee Minute Book, 'Rules for Matrons for Cases on Trial', c.1914.

¹⁴⁰ See for example the homes for 'early care women' and 'men on trial' approved in 1938: WLHUM, MACA, Council Minute Resolutions, 23 September 1938.

future prognosis, and thereby consolidated a shared identity among inhabitants based on some degree of shared experience.

A gradual professionalisation of the MACA's staffing of its homes complemented the increasingly early stage at which it intervened in patients' convalescence in the 1920s and 1930s. As early as 1899, *Hospital* had suggested that elderly retired nurses might prove particularly suitable hosts for mental convalescents.¹⁴¹ The Bath and Bristol Mental Health Society similarly utilised the services of a retired and married couple of ex-nurses for their convalescents in the early 1930s.¹⁴² With the introduction of certified convalescents into the MACA's homes, however, the skilled observation, supervision and attendance associated with professional training seems to have become more important. In 1913, the Association's first secretary H. Thornhill Roxby suggested that some existing homes without trained nurses might prove 'unsuitable' for trial cases, thereby singling-out certified convalescents as in particular need of skilled care.¹⁴³ His successor Ethel Vickers in the 1930s likewise drew particular attention to 'trained' staff and weekly medical attendance in the Association's homes for early cases.¹⁴⁴ Case histories of uncertified aftercare patients in the MACA's reports tended instead to emphasise the importance of rest and a break from the worries of civil life. This selective emphasis on the nursing of certified cases suggests a more professional level of care in the Association's homes resulted from the

¹⁴¹ WLHUM, MACA, Newspaper Cuttings, 'The After Care Association', *The Hospital*, February 1899.

¹⁴² BRO, Bristol County Council, Mental Hospital Minutes, 3 October 1932, p. 116.

¹⁴³ [H. Thornhill Roxby, cited in:] Bond, 'After-Care in Cases of Mental Disorder', p. 285.

¹⁴⁴ LMA, LCC, Mental Hospital Committee, Minutes of Special Sub-Committees, letter from Ethel Vickers to General Purposes Sub-Committee cited in minutes, 1 May 1931; MRC, Association of Psychiatric Social Workers, Vickers, 'Foreword', in Laurie, *Employable or Unemployable?*, p. 1.

translocation of borderline patients – who would previously have remained within mental hospital – into the community. By 1930–31, there were 16 qualified mental nurses across the Association’s c.20–23 homes, apparently including Mr and Mrs Rhodes for trial patients, and Mrs Armstrong’s for early care cases.¹⁴⁵ Trained nurses had therefore become a common if not general feature of cottage home care by the 1930s, influenced initially by the MACA’s expanded role over the convalescence of patients at an earlier stage in their recoveries.

Employment of nurses modified the constructed domestic and familial normality the MACA sought to provide patients. It introduced a layered hierarchy of domestic management, summed-up in the MACA’s 1931 report, which thanked a procession of ‘matrons, their husbands, staff, and other helpers’ for their support.¹⁴⁶ Matrons provided weekly reports to the MACA Westminster offices on the progress of their patients. This centralised decision-making on the basis of first-hand lay assessments. After 1913, homes for trial patients sat at the nexus of voluntary and local authority care, still accountable to the MACA that requested regular updates, but also now to the asylum authorities through the notification of any relapses. The introduction of trained nurses into homes added a level of professionally-recognised skill into the process of observation. Building upon Michel Foucault’s analysis of institutional power relations, Peter Bartlett has argued that nineteenth-century asylums served to inculcate norms of behaviour

¹⁴⁵ LMA, King Edward’s Hospital Fund for London, Particulars of Convalescent Homes Applying for Grants, 1930 and 1931; WLHUM, MACA, Council Minutes, 9 September 1932, 23 September 1932, 31 July 1936, 2 October 1936.

¹⁴⁶ WLHUM, MACA, Annual Report, 1931, p. 6. See also: WLHUM, MACA, *Annual Report*, 1934, p. 6.

through an ongoing process of reclassification and assessment.¹⁴⁷ The expansion of specialist nursing for convalescents in the MACA's homes devolved a function of overcrowded and overburdened mental hospitals into the community-based voluntary sector. In 1926, the Royal Medico-Psychological Association (RMPA) recognised the MACA's cottage homes as a secondary phase of surveillance over patients whose recoveries remained unconfirmed.¹⁴⁸ J.R. Lord too envisaged 'specially designed, equipped, administered and situated' voluntary aftercare homes as an integral part of mental hospital observation and treatment.¹⁴⁹ Consequently, these authors recognised the MACA's increasingly professionally-qualified cadre of nurses as part of a system of skilled medical observation, in ways that to some extent extended and devolved the clinical gaze of the asylum into the wider community.

Environment and a sense of domesticity appear to have been more important to the MACA's vision of cottage home convalescence than employment and activity. Manual employment had formed a large part of (pauper) asylum regimen for recovering and able patients in the nineteenth-century, and became increasingly systematised from the 1920s with the introduction of occupational therapy.¹⁵⁰ The place of work within

¹⁴⁷ Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London and New York: Leicester University Press, 1999), pp. 245-7.

¹⁴⁸ 'The Report of the Royal Commission on Lunacy and Mental Disorder', *Journal of Mental Science* **72** (October 1926), p. 605.

¹⁴⁹ J.R. Lord, "'After-Care" and Other Aspects of Social Service as an Adjunct to Mental Treatment', *Journal of Mental Science* **76** (October 1930), p. 623.

¹⁵⁰ Clare Hickman, 'Vis Medicatrix Naturae: The Design and Use of Landscapes in England for Therapeutic Purposes since 1800' (unpublished PhD thesis: Bristol University, 2006), p. 124; Anne Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', in Jonathan Andrews and Anne Digby (eds), *Sex and Seclusions, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004), p. 240.

convalescence, however, was more ambiguous. Employment appeared in the MACA's publicity as both the desirable proof of mental restitution, yet if unmanaged, also a potential threat to ongoing recovery. Vicky Long has suggested that the MACA aimed pre-eminently to restore patients into economically-active citizens equipped with 'values of labour discipline and bourgeois rationality'. Certainly, as Long has illustrated, the MACA's publicity underlined the benefits of its services to rate-payers, both in avoiding relapse and costly re-institutionalisation, and the positive social and fiscal contribution of its rehabilitated convalescents.¹⁵¹ Case histories reproduced in its annual reports typically concluded with mention of the job patients had secured upon recovery, thereby rhetorically equating mental health with the ability to hold down work. Nevertheless, it is the marked lack of emphasis on employment that perhaps most characterised the MACA's representations of cottage home treatment. Its annual reports of the early 1920s raised the use of homes for providing psychiatric convalescents with a more protracted period of rest than their somatically-afflicted counterparts in general medicine.¹⁵² Moreover, the MACA repeatedly emphasised that its homes shielded patients from a 'world of work and worry', and therefore framed its convalescence as a shield against premature activity and anxiety.¹⁵³ This privileged inactivity over work whilst implicitly raising an expectation that the patient would eventually return to employment.

¹⁵¹ Long, 'Changing Public Representations', pp. 191, 221.

¹⁵² The Association's reports noted that patients sometimes stayed for up to three months under its care. WLHUM, MACA, Annual Report, 1922, pp. 4-5; WLHUM, MACA, *Annual Report*, 1924, pp. 7-8.

¹⁵³ LMA, LCC, Mental Hospitals Committee, Mental Treatment Act Sub-Committee report, 12 February 1931, in 17 February 1931, p. 446; WLHUM, MACA, Publicity and Information Sheets, 'A Beneficent Ministry', *Christian* (6 December 1934); WLHUM, MACA, Publicity and Information Sheets, [no title], c.1938, p. 1.

Cottage homes therefore fulfilled a double-function for the MACA: firstly, temporary recuperation, and, secondly, restitution to employment and self-sufficiency.¹⁵⁴ Some patients do appear to have undertaken training in or immediately after their stay in cottage homes.¹⁵⁵ In other instances, however, case histories suggest they served to provide reassurance and respite for patients worried about re-entry into paid employment or the domestic conditions awaiting them on their return.¹⁵⁶ These potted histories often drew attention to particular socially-situated causes of mental distress, and correlative need for convalescence. The croquet lawns and badminton nets shown in a rare image of the Association's homes (c.1931) have prompted Vicky Long to question whether the charity sought to imply that its temporary retreats restored patients to health through activity.¹⁵⁷ It is also possible, however, to regard the benches as evidence of a more passive approach to recovery, particularly as other images (figures 12–13) showed figures sat outside cottage homes. This perhaps more closely corresponds with Clare Hickman's perception that convalescence in the early twentieth century incorporated significant amounts of rest as well as some exercise.¹⁵⁸ There does seem to be a tension in these images, between rest and a relaxed rural life on the one hand, and the imperative for convalescents to re-engage with some degree of activity on the other. As Long has noted, the text accompanying these images represented its homes as an 'economy' to the

¹⁵⁴ This 'double-purpose' was raised explicitly in one the case history of patient 35760 in the Association's annual report for 1938. [Case 35760, cited in:] WLHUM, MACA, *Annual Report*, 1938, p. 19.

¹⁵⁵ [Case 31506, cited in:] WLHUM, MACA, *Annual Report*, 1936, p. 12.

¹⁵⁶ [Case 22889, cited in:] WLHUM, MACA, *Annual Report*, 1932, p. 13; [Case 24378, cited in:] WLHUM, *Annual Report*, 1933, p. 13; [Case 27443, cited in:] WLHUM, *Annual Report*, 1937, p. 13.

¹⁵⁷ Long, 'Changing Public Representations', p. 221.

¹⁵⁸ Hickman, 'Viz Medicatrix Naturae', pp. 223-4.

cost to rate-payers of relapsed mental patients; at the same time, however, it also detailed the 'brief interval of seasonable repose' the patients themselves experienced.¹⁵⁹ In this, the MACA looked back to past illness, forward to the patient's future employment, and envisaged convalescence as the transition that could make this happen.



Figures 12 and 13: Publicity images of unnamed MACA cottage homes, from *Monthly Pictorial*, December 1934. Both images show seated individuals outside these homes (although indistinct in the reproduction shown in Figure 13, they can be identified under the nearest porch).

Source: WLHUM, MACA, SA/MAC/H.2/1, Publicity Sheets.

¹⁵⁹ WLHUM, MACA, Publicity and Information Sheets, 'The Mental After-Care Association', c.1931, p. 2; Long, 'Changing Public Representations', p. 221.

Only in exceptional circumstances do the MACA seem to have considered the benefit their homes offered mental hospitals in releasing beds for more seriously afflicted patients. In 1939, Ethel Vickers forewarned Evelyn Fox that she anticipated wartime conditions would create a greatly increased demand for convalescent beds 'in order to relieve hospital beds required by the Authorities for urgent cases'. Vickers comments suggest that in times of emergency, its cottage homes could work equally well for patients who may not otherwise have been discharged from mental hospitals.¹⁶⁰ Henry Yellowlees, the charity's President, agreed and 'thoroughly approved' of the use of its homes for cases on prolonged trial who previously only had access of organised care in the form of mental hospital beds.¹⁶¹ The notion that cottage homes might help in 'freeing beds' for recent and acute cases in mental hospitals had already appeared in J.R. Lord's paper on aftercare of 1930. This further corresponded with the BoC's emphasis on the advantages convalescent villas offered to the creation of much-needed asylum beds.¹⁶² The MACA in peacetime, however, tended to emphasise the other point made in Lord's paper: that their homes offered specialist care to convalescents, represented in their description of these homes as 'stepping stones'.¹⁶³ However, the charity had also commenced boarding-out in the 1930s and it is possible therefore that wartime pressures further encouraged

¹⁶⁰ WLHUM, MACA, SA/MAC/E.5/6, Correspondence re Mental Health Emergency Committee, memorandum from E.D. Vickers (MACA) to Evelyn Fox (CAMW), 'Mental Health Emergency Committee', 10 February 1939.

¹⁶¹ WLHUM, MACA, SA/MAC/E.5/6, Mental Health Emergency Committee Correspondence, 'Draft Memorandum for Board of Control in Connection with Deputation', p. 2; WLHUM, MACA, Council Minutes, 8 September 1939, 29 September 1939.

¹⁶² Lord, 'After-Care', p. 623.

¹⁶³ WLHUM, MACA, Annual Report, 1925, p. 5; WLHUM, MACA, Annual Report, 1938, p. 3.

it to extend this to more uncured mental hospital patients, in ways that Vicky Long has suggested developed further after the war.¹⁶⁴

Cottage home convalescence provided patients with a place for recovery that incorporated aspects of both institutional medicine and domestic care-giving. The evidence of the MACA's management of homes suggests it prioritised a therapeutic domesticity based primarily around a temporary 'change', sociability and moral support. This implicitly challenged the ability of some families and domestic environments to sustain health. In this prioritisation of third-party observation and guidance, aimed at restoring patients to a future life of productive labour, the MACA perhaps extended into the community the moral control over patients that Foucault and others have identified within the asylum.¹⁶⁵ The Association's case histories commonly followed the patients' progress to the workplace, even while the charity itself often chose to selectively emphasise the protective function of its convalescence. At the same time, the smaller scale, discreet seaside or country locations, and domestic management of the MACA's homes were also represented as preferable to what mental hospitals could offer. This tacitly critiqued the ability of mental hospitals to achieve sustainable psychiatric cures without some measure of community care. Early care cottage homes took the principle of separate and home-like care for convalescents further than institutional convalescent villas, by introducing a space where patients could entirely avoid contact with mental hospitals. In practice, this relied upon out-patient treatment, and a new site for

¹⁶⁴ Long, 'Changing Public Representations', p. 193.

¹⁶⁵ Michel Foucault, *History of Madness* (London and New York: Routledge, 2006), pp. 427, 485; Bartlett, *Poor Law of Lunacy*, p. 246; Danielle Terbenche, "'Curative" and "Custodial": Benefits of Patient Treatment at the Asylum for the Insane, Kingston, 1878-1906', *Canadian Historical Review* 86:1 (March 2005), pp. 36-7.

cooperation between mental health professionals and the voluntary sector.¹⁶⁶

Nevertheless, the claims the MACA made for cottage home convalescence as a 'bridge' between institutional and private care set it apart from either, as a constructed and idealised version of domestic life unobtainable in either public hospital or private home.

4. Local and National Growth in Voluntary Provision for Convalescence

Diversification of the MACA's services between the wars expanded the nature of its engagement with mental health, the groups and places that it targeted, and the scale of its operations. As with the proliferation of convalescent villas within hospitals, charitably-sourced convalescent services witnessed notable growth in interwar England, and a high level of official support. Aftercare received prominent attention in the Cobb Committee (1923) and Macmillan Commission's (1926) reports, which emphasised its importance, whilst identifying the MACA as the only named source.¹⁶⁷ Unsurprisingly given the high profile of these inquiries, the Association heavily cited the conclusions of the Macmillan Commission in its publicity, as evidence of the need for more charity to support the national development of its services.¹⁶⁸ The BoC's annual reports also focused

¹⁶⁶ Scull, 'Psychiatry and Social Control', pp. 162-5; Mathew Thomson, 'Community Care and the Control of Mental Defectives in Inter-war Britain', in Peregrine Horden and Richard Smith (eds), *The Locus of Care: Families, Institutions and the Provision of Welfare since Antiquity* (London and New York: Routledge, 1998), p. 199.

¹⁶⁷ *Report of the Committee on Administration of Public Mental Hospitals* (London: H.M. Stationary Office, 1923), pp. 63-4; *Report of the Royal Commission on Lunacy and Mental Disorder* (London: H.M. Stationary Office, 1926), pp. 23, 82.

¹⁶⁸ MACA *Annual Report*, 1926, p. 4; WLHUM, MACA, Scrapbooks, 'Mental After-Care: Workers Encouraged by Royal Commission's Report', *Manchester Evening News*, 9 August 1926; MACA *Annual Report*, 1927, pp. 4-5; 'Charity Meeting: The Mental After Care Association: Convalescence of Patients: Sir Charles Wakefield's Appeal', *The Times* (Friday 30 March 1928), p. 9, col. F; MACA *Annual Report*, 1930, pp. 5-7.

particularly on the benefits of aftercare, as Kathleen Jones has noted, which in some years extended to a separate section on the MACA's activities. Such prominent and high profile support helped legitimate the MACA's services as a routine component of asylum discharge procedures, although unlike the Macmillan Commission and National Council for Mental Hygiene (NCMH), the BoC also accepted that aftercare might be provided through other charities and (after 1930) local authorities.¹⁶⁹ A diverse range of organisations subscribed to its funds by the early 1920s, including the BoC and King Edward's Hospital Fund, indicating their support for the Association's activities, even if the sums represented only a tiny fraction of annual income.¹⁷⁰ The RMPA also voted annual payments to the MACA after 1925, including an exceptional payment of £100 in 1927.¹⁷¹ Such payments represent a small but symbolic acknowledgement amongst medical and lay bodies of the MACA's integral place within English psychiatric services.

¹⁶⁹ Jones, *Asylums and After*, pp. 128, 134. See for example: BoC, *Annual Report*, 1924, p. 28; BoC, *Annual Report*, 1932, p. 44; BoC, *Annual Report*, 1937, p. 37.

¹⁷⁰ Following earlier contributions from the Lunacy Commission before the war, the Board of Control regularly made small payments. See also Figure 1. *Ibid.*, p. 127; WLHUM, MACA, *Annual Report*, 1924, p. 5.

¹⁷¹ 'Medico-Psychological Association of Great Britain and Ireland', *Journal of Mental Science* **69** (October 1925), p. 808; MACA Annual Report, 1926, p. 7; 'Medico-Psychological Association of Great Britain and Ireland', *Journal of Mental Science* **71** (October 1927), p. 711.

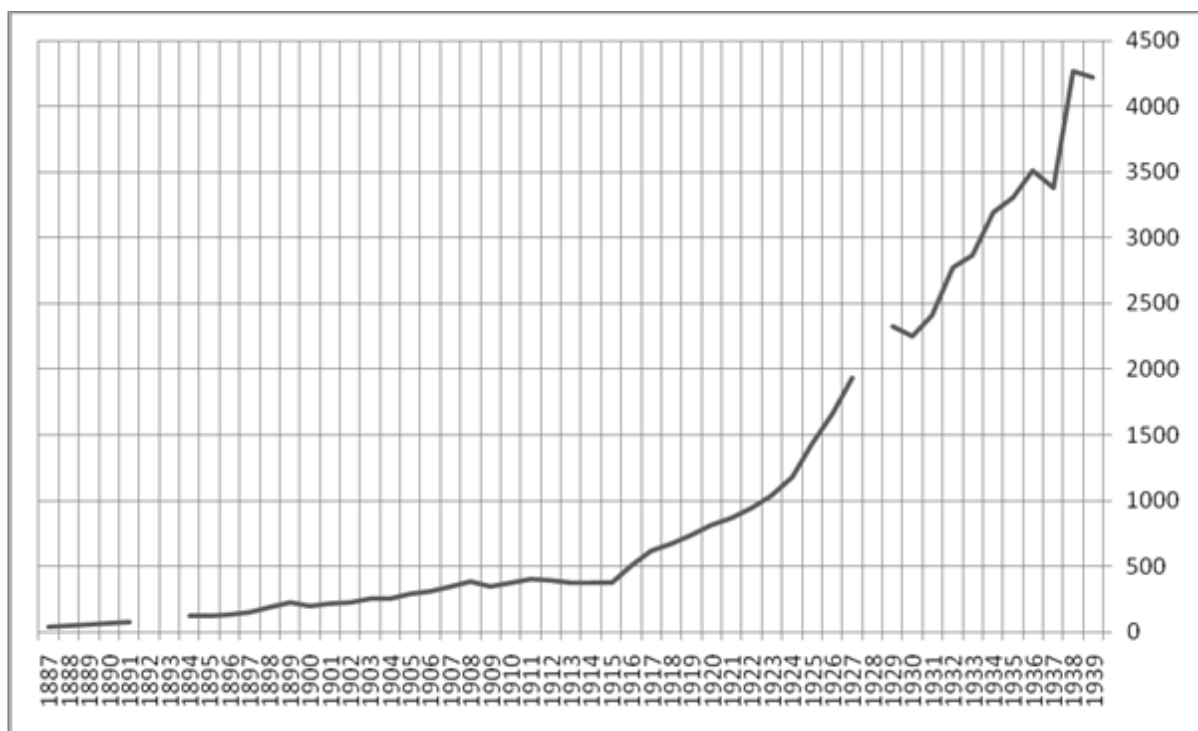


Figure 14: Cases Handled by the Mental After-Care Association (MACA), 1887–1939.¹⁷²

Source: WLHUM, MACA, *Annual Reports*, 1936–39; Roof, *Voluntary Societies and Social Policy*, Tables 1-2, pp. 96-7, 119

The MACA’s caseload rose dramatically between the wars, rising almost sevenfold between 1918 (620 cases) and 1938 (4,269 cases). Figure 14 illustrates the relatively steady expansion of the MACA before 1916, and more rapid growth thereafter sustained and even slightly accelerated to the late 1930s. Historians have offered a number of explanations for this ongoing burgeoning in activity. Madeline Roof and Kathleen Jones have attributed the charity’s apogee during the 1930s to the LCC’s practical demand for

¹⁷² WLHUM, MACA, *Annual Reports*, 1936-39; Roof, *Voluntary Societies and Social Policy*, Tables 1-2, pp. 96-7, 119; WLHUM, MACA, SA/MAC/D.1, Draft Annual Financial Accounts, 1906, 1913, 1916, 1926, 1936; LMA, King Edward’s Hospital Fund for London, ‘Particulars (1930) of Convalescent Homes’, 1931, p. 2.

services, and the BoC's vocal advocacy, rather than changes within the MACA itself.¹⁷³ In contrast, Vicky Long has suggested that the Association's improving fortunes may have been connected to its members. She has particularly raised the contribution of Ethel Vickers, whose time as secretary between 1915–40 coincided closely with the period of its greatest expansion, and Lord Wakefield, whose pecuniary beneficence led one contemporary commentator to describe him as the Association's 'fairy godfather'.¹⁷⁴ A lack of consensus therefore exists among historians over the extent to which the MACA contributed to its own growth, and the influence of outside agencies in increasing demand for its services. Jones has dated expansion principally to the LCC's payment of maintenance grants for trial patients in 1919, and therefore to quasi-contractual funding arrangements. Conversely, Susannah Strong has pointed to the charity's worsening deficit, yet has also indicated that its caseload expanded throughout the period. Instead, Strong has linked the charity's growth with diversification, which she has argued followed post-war public demand for alternatives to the asylum in the provision of mental health care.¹⁷⁵

In certain years at least, as Madeline Roof and Kathleen Jones have argued, the LCC appears to have directly catalysed the Association's expansion.¹⁷⁶ In November 1915 the Association agreed to visit the homes of recovered patients discharged from the LCC's asylums, in cases where the

¹⁷³ Roof, *Voluntary Societies and Social Policy*, pp. 118-9; Jones, *Mental Health and Social Policy*, p. 106; Jones, *Asylums and After*, p. 128.

¹⁷⁴ Long, 'Changing Public Representations of Mental Illness', pp. 181, 230; Winterton, *Mending Minds*, p. 167.

¹⁷⁵ Susannah Strong, *Community Care in the Making: A History of MACA, 1879-2000* (London: MACA, 2000), p. 25; Jones, *Asylums and After*, p. 128.

¹⁷⁶ Roof, *Voluntary Societies and Social Policy*, pp. 116-8; Jones, *Mental Health and Social Policy*, pp. 103-6.

deservingness of applicants for financial aid through the Council's Queen Adelaide Fund (QAF) was in question.¹⁷⁷ At this meeting with the LCC, the MACA anticipated that the arrangement would lead to a 'largely increased scope of work' on its introduction in 1916.¹⁷⁸ The notable increase in the MACA's caseload in this year (Figure 14), suggests growth may have occurred as a direct result of these arrangements. This conclusion is to some extent supported by financial data. Figure 15 shows that combined payments for trial and QAF cases rose absolutely and proportionally in 1916 and 1917 to account for almost a fifth of income in these years. Local authority funding in the 1930s also increased most noticeably in 1934 and 1937–8, coinciding with the commencement of boarding-out (1933) and holiday home placements for working in-patients (1937–38) at the LCC's asylums. Those years of most notable expansion in case numbers – 1916, 1925, and 1938 – in each case followed the introduction of a new area of work in the previous twelve months (respectively social work for the QAF, early care, and holiday care: Figure 14). To a significant extent, as letters the Association's chairmen published in *The Times* attest, the MACA had always worked most closely with the LCC in developing new services.¹⁷⁹ It seems likely therefore that this authority contributed to the MACA's augmented caseload, most notably in

¹⁷⁷ The Queen Adelaide Fund, established in c.1835, provided financial support for pauper patients whose stay in London mental hospitals had been funded through local Boards of Guardians, and after 1930 through Public Assistance Committees. Patients were eligible if they had been discharged within the previous five years. See LMA, LCC, Mental Hospitals Committee, Presented Papers, memorandum (24 June 1927) from Montagu H. Cox (Clerk of the London County Council), on behalf of the Local Government Committee, to the Mental Hospital Committee, 'Queen Adelaide's Fund', 28 June 1927.

¹⁷⁸ MACA, *Annual Report*, 1915, p. 7; 'Mental After-Care Association', *Journal of Mental Science*, **62** (April 1916), p. 463.

¹⁷⁹ WLHUM, MACA, Newspaper Cuttings, [Henry Yellowlees, cited in:] 'Mental Health', *The Times*, 10 June 1943.

1916 and 1937–8 when it became the sole beneficiary of services that extended the charity's care over new groups of patients.

Nevertheless, in other years the introduction of the LCC's support seems to have made relatively little difference. In 1919 the MACA entered into a quasi-contractual relationship with the LCC to receive maintenance payments in return for trial cases boarded at its homes. While Kathleen Jones has dated the commencement of the MACA's interwar expansion to this agreement, Figure 15 suggests the origins of its growth had begun at least three years earlier.¹⁸⁰ The charity's overall income for 1916–17 remained significantly below pre-war levels (Figure 15), so it seems unlikely that the acceleration in case numbers in this year derived from an aggregate increase in revenue. Certainly, as Jones has argued, the LCC's direct payments had a symbolic importance, and consolidated its strong relationship with the MACA. But in other respects, 1919 appears an unexceptional year in the charity's ongoing growth. It seems rather that growth accelerated most noticeably after diversification had introduced entirely new classes of recipient into the charity's orbit. These spurts are identifiable in Figure 15 after 1916–17 (QAF cases and war victims), 1924 (early care cases), and 1937 (working in-patients sent on holidays). More subtly, increases are also apparent after 1931 (voluntary and temporary patients) and 1933 (boarding-out). The Association itself attributed its continual growth to a greater awareness amongst specialists, local authorities and the public of its work, and to a commensurate increase in

¹⁸⁰ Jones, *Asylums and After*, p. 128.

demands on its services.¹⁸¹ The coincidence of periods of growth with the development of new work, however, suggests the MACA to a significant degree authored its own expansion into new areas of activity. Part of this resulted from an expanded concept of convalescence. The rate of expansion, however, also appears to betray a more general expansionism over other types of cases (boarded-out in-patients) whose treatment centred instead on palliative care.

Official protection given to the MACA during World War One perhaps nurtured the charity's ongoing diversification. Herbert Samuel's War Charities Act, 1916, required the registration of all charities making public appeals in aid of war work, in an attempt to stem the proliferation of voluntary activity in this area.¹⁸² Registration officially recognised and endorsed the MACA's contribution to the war effort, enabling the charity to redefine its role in social welfare and national health, and pursue new appeal strategies. It based its appeal strategy after 1917 partly upon its engagement in 'war work', citing the aftercare it provided military and civilian casualties as a reason for increased public philanthropy.¹⁸³ Arguably the charity's placement on a list of reserved occupations proved a more important precondition to growth, because it enabled its administration to function relatively normally, ensuring a cadre of voluntary workers remained permanently at its disposal. On the

¹⁸¹ [R.Percy Smith, cited in:] 'Charity Meeting: The Mental After Care Association', *The Times* (Friday 30 March 1928), p. 9, col. F; WLHUM, MACA, *Annual Report*, 1936, p. 2.

¹⁸² Elizabeth Macadam, *The New Philanthropy: A Study of the Relations between the Statutory and Voluntary Social Services* (London: George Allen and Unwin, 1934), pp. 36-7; Frank Prochaska, *The Voluntary Impulse: Philanthropy in Modern Britain* (London and Boston: Faber and Faber, 1988), pp. 74-6; Jane Lewis, 'The Boundary between Voluntary and Statutory Social Service in the late Nineteenth and Early Twentieth Centuries', *Historical Journal* **39** (March 1996), pp. 175-6.

¹⁸³ MACA, *Annual Report*, 1917, p. 3; 'Shell-Shock Treatment', *The Times* (Thursday 13 March 1919), **42047**, p. 15, col. F; WLHUM, MACA, Scrapbooks, 'For Mental Cases: Care of Shell Shock Patients', *Christian World*, 20 March 1919; MACA, *Annual Report*, 1920, p. 4. Compare: WLHUM, MACA, *Annual Report*, 1916, p. 3.

eve of war in 1939 the MACA's secretary Ethel Vickers again sought to secure reserved status for the charity, arguing that in the previous conflict it had proven 'very essential', enabling the charity to respond to need by ensuring the availability of experienced staff. It is clear that the MACA's representatives at the Emergency Mental Health Committee in February 1939 anticipated a rise in demand for aftercare due to wartime conditions. Vickers in particular emphasised the pressures placed on its residential services as a result of local authorities turning-over asylum accommodation for 'urgent' cases.¹⁸⁴ At ex-asylum war hospitals such as Norfolk and Horton, virtually all civilian residents had been relocated to other institutions or into the community in 1915.¹⁸⁵ Locally, this created the conditions for an enhanced role for voluntary aftercare, which the MACA was able to support through the official protection extended to its volunteers and activities during wartime.

Financial growth therefore appears to have followed, rather than caused, the initial surge in the number of applicants taken into the Association's care during the First World War. Thereafter, income multiplied even faster than the recipients of its charity, to a level over thirteen times higher in 1939 compared with 1917, adjusted for inflation (Figure 15). Wartime exigencies invigorated many charities, Prochaska has argued, providing new opportunities for diversification and expansion.¹⁸⁶ It catalysed the MACA's diversification at least into new areas such as war casualties

¹⁸⁴ WLHUM, MACA, Mental Hospital Emergency Committee, Minutes, re deputation of Board of Control, February 1939, and memorandum from Ethel Vickers to Evelyn Fox (Secretary, CAMW), 'Mental Health Emergency Committee', 10 February 1939.

¹⁸⁵ Fisher, 'Getting Out of the Asylum', p. 197; J.R. Lord, *The Story of Horton Hospital (Co. of London) War Hospital, Epsom: Its inception and Work, and Some Reflections* (London: W. Heinemann, 1920).

¹⁸⁶ Prochaska, *Voluntary Impulse*, p. 76.

and patients supported through the LCC's QAF (see Appendix 1). It arguably proved successful in sustaining this growth due to support from local and central government, patients and their kinship groups. Between 1916 and 1928, local authority payments remained relatively stable at between 16–20 per cent.¹⁸⁷ This is slightly higher than in the voluntary hospitals Steven Cherry has studied, which typically received approximately ten per cent of their income from central and local government sources.¹⁸⁸ That part of the Association's work devoted to cottage home convalescence, however, relied much more on direct local authority funding. Maintenance grants were provided through the LCC for cases on trial from 1919, and for temporary and voluntary patients discharged from mental hospitals, and early care patients treated through its clinics. These payments were calculated at the same rate as the cost of in-patient treatment together with a capitation fee to cover administration, and travelling expenses.¹⁸⁹ Because such payments covered the cost of residence and overheads at an equivalent rate to in-patient treatment, they acted as an extension of local authority treatment, effectively contracting-out convalescence. Through subsidisation, the LCC and at least some other authorities such as Bristol and Yorkshire recognised community-based convalescence as an area in which the public sector had significant responsibilities.¹⁹⁰

¹⁸⁷ See Figure 15 and Appendix 1.

¹⁸⁸ Steven Cherry, 'Before the National Health Service: Financing the Voluntary Hospitals, 1900–1939', *Economic History Review* **50** (May 1997), p. 315.

¹⁸⁹ WLHUM, MACA, Council Minutes, letter from H.F. Keene (Chief Officer, LCC Mental Hospital Committee) 14 November 1919; LMA, LCC Mental Hospitals Committee, General Purposes Sub-Committee, Minutes, fifth report of Mental Treatment Act Sub-Committee, 7 May and 18 June 1931, p. 537.

¹⁹⁰ Board of Control, Annual Report, 1934 [York City Mental Hospital, visited 31 January 1934], p. 389; BRO, Bristol City Council, Mental Hospital Committee, Minutes, 6 July 1936, p. 263.

It appears, therefore, that while direct payments from local authorities in themselves made little difference to the numerical growth in the MACA's caseload, they importantly shifted a significant part of convalescence to local authority control. Section 6(3)(b) of the Mental Treatment Act, 1930, for the first time allowed local authorities to reimburse the Association for convalescent services provided to uncertified patients, including those discharged recovered, or treated as voluntary and temporary patients. Around the same time, the Local Government Act, 1929, swept away local board of guardians that had until this date provided grants to the MACA for psychiatric patients treated in poor law infirmaries. In the light of both these statutes, the LCC's General Purposes Sub-Committee concluded that the 'primary duty' for aftercare fell to mental hospital authorities rather than to public assistance.¹⁹¹ A slim Board of Control file of queries from local authorities on the application of Section 6(3b) indicates that some mental hospitals such as Cotford (Somerset) and Nottingham City may have differed in their view. Both these authorities enquired into the possibility of charging the costs of aftercare to the Public Assistance Committees established to replace the old Boards of Guardians.¹⁹² Because these committees brought poor relief under direct local authority control for the first time, they introduced the possibility of a functional reallocation of aftercare within the same authority.¹⁹³ Cotford and Nottingham's enquiries show some mental hospitals at least considered the possibility that aftercare might form part of

¹⁹¹ LMA, LCC Mental Hospitals Committee, General Purposes Sub-Committee, 22 November 1932, pp. 2-3.

¹⁹² The National Archives [TNA], Board of Control [BoC], MH/51/253, Correspondence File: 'Mental Treatment Act, 1930, After-Care', memorandum between Cotford Mental Hospital and Board of Control, 9 December 1931, and memorandum, Nottingham City Mental Hospital to Board of Control, 3 January 1934.

¹⁹³ Martin Powell, 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History* 8 (September 1997), pp. 335, 345.

local authorities' social welfare functions, rather than a medical responsibility of mental hospitals. The BoC, however, decided that responsibility for aftercare payments should remain with mental hospital visiting committees, confirming convalescent aftercare as primarily a medical rather than social duty.¹⁹⁴

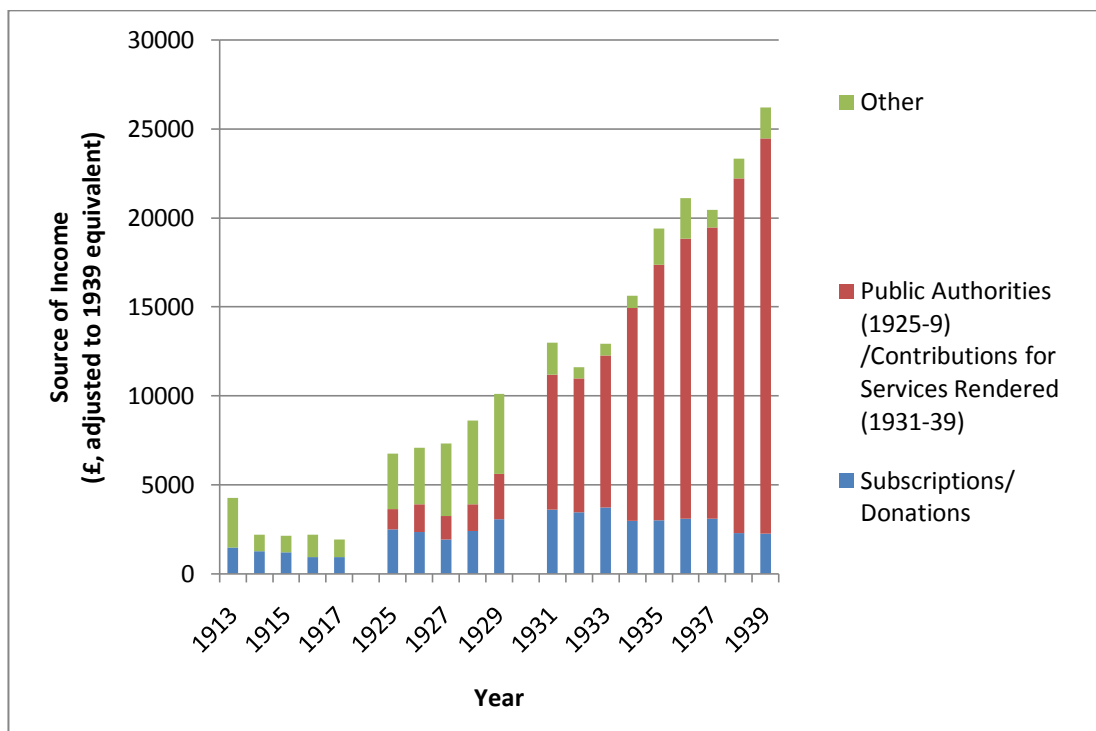


Figure 15: Mental After-Care Association, Sources of Income, 1913–17, 1925–29, 1931–39. Totals have been adjusted for inflation (1939 values). See Appendix 2 for a more detailed breakdown of revenue.

Source: Source: WLHUM, MACA, SA/MAC/D.1/24-43, Draft Annual Financial Accounts, 1913–39

¹⁹⁴ TNA, BoC, Correspondence File: After-Care, memorandum between Board of Control and Cotford Mental Hospital, 11 December 1931, and H.J. Clarke (BoC) to Public Assistance Officer, Buckinghamshire County Council, 5 January 1935.

Figure 15 indicates the MACA's growing reliance on local authority payments for services rendered, which during the 1930s increasingly overtook proceeds from subscriptions and donations as its most important source of revenue. This appears to have occurred gradually between the admittance of trial patients in 1913 and the early 1930s, so that while the value of voluntary income remained relatively stable it declined as a proportion of total income. In turn, service-related payments rose inexorably from 1934, probably as a result of the use the LCC made of the MACA from this year for boarding-out.¹⁹⁵ These accounted for more than four-fifths of income in 1937–39, and more than compensated for stagnant or slightly declining charitable receipts. Financially at least, the MACA conforms more closely to Jane Lewis and Geoffrey Finlayson's analysis of a cooperative convergence between the voluntary sector and local government, than Frank Prochaska's depiction of largely autonomous separate spheres.¹⁹⁶ Authorities such as the LCC that were prepared to invest in the voluntary convalescence and care of patients assumed an increasingly large monetary stake in the charity's operations. The beneficence of the LCC in particular tied the MACA's activities ever more closely to metropolitan aftercare, even as the Association's reports claimed its expanding geographical sphere of influence through local branch-work.¹⁹⁷ The charity's budgets became less detailed over time, making it difficult to ascertain the source of service-

¹⁹⁵ WLHUM, MACA, Council Minutes, re interview between R.H. Curtis (Chief Officer, LCC Mental Hospitals Committee) and Ethel Vickers (Secretary, MACA), 13 October 1933; LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee, 'Lunacy Acts: Placing Out of Patients on Extended Leave on Trial', 16 May 1933, 17 April 1934, pp. 281, 436-7.

¹⁹⁶ Prochaska, *The Voluntary Impulse*, p. 80; Jane Lewis, *The Voluntary Sector, the State, and Social Work in Britain* (Aldershot, Hants and Brookfield, Vermont: Edward Elgar, 1995), p. 15; Geoffrey Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare, 1911-1949', *Twentieth Century British History* 1 (April 1990), pp. 199-200.

¹⁹⁷ WLHUM, MACA, *Annual Report*, 1929, p. 3; WLHUM, MACA, *Annual Report*, 1931, p. 3.

related contributions.¹⁹⁸ Nevertheless, the evidence of the Cobb and Macmillan reports and the King Edward's Hospital Fund indicate that London contributed a significant majority of the Association's patients in the 1920s and early 1930s.¹⁹⁹ Because such a substantial proportion of the charity's income derived from direct payment by the late 1930s, it appears the Association may have increasingly supplied services linked to the LCC's interests in managing its own recuperating and chronic patient population.

Alongside undeniable financial and numerical growth, the MACA faced significant criticism over the limited geographical reach of its services. From at least the 1880s, the MACA had sought to publicise the cumulative expansion of its charity by listing the various asylums it had supplied help to since its inception. Reports prominently advertised the claim that the charity assisted cases from 'all parts of the Country', which perhaps intentionally obscured the fact that, despite a broad notional range, the majority of cases came from London.²⁰⁰ As early as 1904, the *JMS* referred to an 'oft-repeated suggestion that the Association should decentralize', which it felt had informed the MACA's decision to appoint voluntary local secretaries in 1898, and then contemplate branch-work.²⁰¹ Branches established in Derbyshire, South Essex (Brentwood), and North Staffordshire during 1904–05 formed

¹⁹⁸ Previously in the 1910s and 1920s reports had separately listed payments from patients and friends (which are included under 'other' in Figure 1). These appear to have been amalgamated under 'contributions for services rendered' from the sharp fall in the proportion of income classified under 'other', and the simultaneous introduction of the 'contributions for services rendered' category in 1931: see Figure 1.

¹⁹⁹ *Report of the Cobb Committee*, p. 63; *Report of the Macmillan Committee*, p. 164; LMA, King Edward's Hospital Fund for London, 'Particulars (1930) of Convalescent Homes not Attached to London Hospitals Applying for Grants in 1931', 1931, p. 2.

²⁰⁰ A list of asylums helped since the MACA's inception appeared in each annual report from its first in 1888/9. The cover of these reports also advertised its claim to be the 'only charity of its kind in the United Kingdom', and to help cases from across the country between 1890/1-1920.

²⁰¹ 'After-Care Association', *Journal of Mental Science* 51 (April 1904), p. 312.

the nucleus of an intended national network of locally-organised aftercare provision throughout England and Wales. These divisions resulted from the recommendations of a sub-committee appointed to investigate ways to extend the MACA's work, which concluded during 1904 in favour of locally appointed and administered, but centrally approved and funded divisions to 'deal with cases in their respective Districts'. The sub-committee envisaged these branches as partly-autonomous satellites of the central London-based Association, intended to source cases and homes locally, and thereby increase the number of each at a national level.²⁰² Financial constraints on the charity's budget at the time, however, led the *JMS* to comment that new centres would only be established with 'difficulty', whilst the *Lancet* believed it would necessitate the mobilisation of public finances. Already, the *Lancet* envisaged the need for a tenfold increase in the Association's caseload to meet a national need, presupposing a rise in the number of charitable aftercare cases from 250 to 2,500 per annum.²⁰³

Co-extension of trial care across the public and voluntary sectors in 1913 brought the MACA closer to psychiatric practice, and arguably contributed to an expectation that it should fulfil its functions at a national level. At the inaugural Derby branch meeting in 1904, the local superintendent Dr MacPhail had reasoned that only ten per cent of cases discharged from his asylum would require aftercare, because most cases could be discharged on trial and had homes suitable to sustain recovery.²⁰⁴

Once the MACA began assisting trial cases, it too became involved in a

²⁰² WLHUM, MACA, Scrapbooks, 'Suggestions of the Sub-Committee on the Extension of the Work of the After Care Association', 9 March 1904.

²⁰³ 'The After Care Association', *Lancet*, 'After Care Association' [1904], p. 589.

²⁰⁴ WLHUM, MACA, Scrapbooks, 'New Philanthropic Society in Derby', *The Derby Express*, 13 October 1904.

practice that MacPhail felt should form part of standard discharge procedures for all patients. As a result, those such as Hubert Bond who proposed the MACA's intervention into trials recommended the Association should handle greater numbers than either the *Lancet* or MacPhail had envisaged in 1904. In 1913 Bond argued that approximately 2/9ths of all cases (c. 1,500) 'urgently' required aftercare, while the vast majority of the 7,000 patients discharged annually from British asylums would derive some benefit.²⁰⁵ Community care in Bond's argument turned from being an exceptional to an expected part of discharge. Despite dramatic growth in the numbers treated after 1916, the Association would come under sustained pressure during the interwar period to achieve national coverage, both numerically and geographically. The Cobb Committee recommended in 1923 that aftercare 'needs to be considerably strengthened and extended, particularly in the provinces', having noted the MACA's activities concentrated on London.²⁰⁶ The Macmillan Commission sustained this pressure, arguing that with only 'sporadic' local organisation, the MACA was unable to support all those who found 'the transition from asylum life to the everyday world... a stage of peculiar difficulty'.²⁰⁷

Hubert Bond appealed in 1913 for 'a refusal to be content until an active branch has been established for each local authority'.²⁰⁸ Even by 1939, however, the administration of aftercare remained to a significant extent centred on London. Every mental hospital in London used the Association's services by 1931, yet the Association could only claim two

²⁰⁵ Bond, 'After Care in Cases of Mental Disorder', p. 283.

²⁰⁶ *Report of the Cobb Committee*, p. 79.

²⁰⁷ *Report of the Macmillan Commission*, p. 23.

²⁰⁸ Bond, 'After Care in Cases of Mental Disorder', p. 278.

years earlier to have worked with 'more than half' of all hospitals in England and Wales, leaving many more outside its reach.²⁰⁹ Moreover, because the MACA only listed those hospitals it had worked with at some point, some of these may not have been regular users of the Association's services. Figures from the King Edward's Hospital Fund showed that despite the formation of a number of provincial branches, four-fifths of cases in 1930 (1,808 of 2,253: 80.2 per cent) originated from the capital.²¹⁰ Organisationally too, the MACA remained firmly centred around London. Some provincial branches such as Norfolk and York independently negotiated local cottage home places for their convalescents.²¹¹ Most, however, appear to have relied on those sourced through the central MACA in London, which remained principally confined to the south-east of England.²¹² Bristol Mental Hospital's superintendent complained in 1932 that 'cases undertaken by the Society have to travel to London to be put in one of their homes on the South or East Coast', despite the existence of a Bristol branch of the MACA.²¹³ Analysis of council minutes and resolutions for the location of these homes between 1917–20 and 1927–39 shows that of thirty-one in named locations, twenty-seven were in London and the home counties.²¹⁴ Much of the growth that

²⁰⁹ WLHUM, MACA, [Anon.], 'Rough but Detailed Notes from Four Scrap-Books', p. 27; MACA, *Annual Report*, 1929, p. 3.

²¹⁰ LMA, King Edward's Hospital Fund for London, 'Particulars (1930) of Convalescent Home', p. 2.

²¹¹ [Norfolk:] WLHUM, MACA, 1928, p. 11; WLHUM, MACA, *Annual Report*, 1932, p. 16.

²¹² See for example: [Devon:] WLHUM, MACA, *Annual Report*, 1925, p. 10; [Hampshire:] WLHUM, MACA, *Annual Report*, 1925, p. 11; WLHUM, MACA, *Annual Report*, 1929, p. 19; [Wiltshire:] WLHUM, MACA, *Annual Report*, 1928, pp. 11-12; [Worcestershire:] WLHUM, MACA, *Annual Report*, 1937, p. 16.

²¹³ BRO, Bristol County Council, Mental Hospital Committee Minutes, 3 October 1932, p. 116.

²¹⁴ Eight in Sussex, five in Kent, five in Surrey, five in Essex, four in London, and one each in Berkshire, Hampshire, Oxfordshire, and Bedfordshire. Twenty-nine other proprietors were named, and a further two house names, without mention of their location. WLHUM, MACA, SA/MAC/C.2/2-5; Council Minutes, April 1917–October 1920, January 1927–September 1939; WLHUM, MACA, , Council Minute Resolutions, September 1921–February 1933.

occurred between the wars therefore took place in London, which was closer both to the MACA's central offices in Westminster and the majority of its cottage homes.²¹⁵

Direct co-operation with the CAMW was first considered in 1923, on the suggestion of Evelyn Fox (Secretary, CAMW) that the two charities could work together to support the aftercare of ex-servicemen discharged from MoP centres in Lancashire and elsewhere.²¹⁶ Minutes of the MACA sub-committee that went on to consider broader collaborative coordination suggest it perceived a clear functional distinction between the two charities. At the same time some – notably Maurice Craig – were prepared to contemplate some degree of mutual working. In the event of coordination, future MACA chairman R. Percy Smith felt that because 'convalescent mental people did not like being taken for defectives' its administration should be kept 'very distinct'. His statement admitted the possibility of inter-charity collaboration over the convalescence of this class of rehabilitees, whilst seeking to strongly demarcate mental illness from mental retardation. At the same time, Percy Smith raised the stigma of mental deficiency as a potential impediment to closer cooperation.²¹⁷ This reflected a similar keenness to keep convalescents distant and distinct from irrecoverable patients evident in the admission and convalescent villas within mental hospitals. Whereas medical superintendents could engineer the placement of convalescents within mental hospitals, inter-charity collaboration threatened to associate them with mental defectives. It seems likely that superintendents

²¹⁵ WLHUM, MACA, [Anon.], 'Rough but Detailed Notes from Four Scrap-Books', p. 6.

²¹⁶ WLHUM, MACA, Special Sub-Committee Minutes, 25 July 1923.

²¹⁷ Ibid., 1 August 1923.

may have been concerned about the stigma of associating their professional activities with mental deficiency, which Mathew Thomson has described as a 'professional backwater' in this period.²¹⁸ In 1924, Ethel Vickers noted 'several places where the superintendents prefer the work to be distinctly apart'.²¹⁹ In a later sub-committee meeting, another superintendent echoed Percy Smith's comments, but from the perspective of the 'many' superintendents who he felt 'objected to their patients being visited by people who deal with M.D.s'.²²⁰ The benefit to patients was less clear in these statements than superintendents' aversion to the closer ties with a charity primarily associated with mental deficiency.

The MACA has achieved a reputation among many historians as an essentially metropolitan charity.²²¹ Nevertheless, as Figure 4 illustrates, the Association between 1904 and 1925 had already developed a number of local branches, even though most counties remained without.²²² By 1925 the Association had at least temporarily gained some degree of representation in areas such as the West Midlands, East Anglia, and parts of the north and south-west. Yorkshire appears to have maintained a particularly active branch, benefiting from the participation on its committee after 1928 of representatives of the local authorities and mental hospitals for the various

²¹⁸ Mathew Thomson, "'Though Ever the Subject of Psychological Medicine": Psychiatrists and the Colony Solution for Mental Defectives', in Hugh Freeman and German E. Berrios (eds), *150 Years of British Psychiatry, Volume II: The Aftermath* (London and Atlantic Highlands, NJ, 1996), p. 136.

²¹⁹ WLHUM, MACA, Special Sub-Committee Minutes, 4 November 1924.

²²⁰ Ibid., [Dr Whitwell, cited in:] memorandum re coordination and training of social workers, n.d. [1930].

²²¹ Roof, *Voluntary Societies and Social Policy*, pp. 118-9; Jones, *Mental Health and Social Policy*, p. 106; Hugh Freeman and D.H. Bennett, 'Origins and Developments' in Douglas Bennett and Hugh Freeman (eds), *Community Psychiatry* (London: Churchill Livingstone, 1991), p. 41; Juliet D. Hurn, 'The History of General Paralysis of the Insane in Britain, 1830 to 1950' (unpublished PhD thesis, University of London, 1998), p. 254.

²²² Fisher, 'Getting Out of the Asylum', pp. 14, 209-10, 254; Strong, *Community Care in the Making*, p. 20.

regions in served.²²³ Its organisational maturity can be gauged from the fact it sourced its own cottage homes for convalescents, and retained a regular section devoted to its activities in the central MACA's annual reports from 1929.²²⁴ This was, however, perhaps exceptional. While the Association's annual report for 1933 reported specific instances where local divisions were 'very flourishing and increasingly active', it also lamented that generally they required 'much building up'.²²⁵ Henry Rayner complained in 1924 that previous attempts to form branches had 'failed for want of money and proper support', but felt optimistic that 'more help would come from the Counties'.²²⁶ To encourage this, the Council wrote to all superintendents the same year asking for help in creating branches.²²⁷ It adopted the Macmillan Commission's criticisms on the patchiness of its work as its own, thereby redirecting blame to the provinces themselves.²²⁸ Thereafter, the Association remained committed to the principle that a national extension of aftercare depended upon local voluntary action. It sought to inspire superintendents and voluntary workers in the regions to create and maintain branches, placing the onus on local activism rather than on central coordination.²²⁹

Dissatisfaction with the national distribution and availability of aftercare became more vocal during the 1930s, as some commentators called for a more radical reconfiguration of service provision. The implication of patchy local MACA branch-provision and local authority-use of the central

²²³ Winterton, *Mending Minds*, pp. 169; MACA, *Annual Report*, 1928, p. 13.

²²⁴ WLHUM, MACA, *Annual Report*, 1936, p. 16.

²²⁵ *Ibid.*, 1933, p. 6.

²²⁶ WLHUM, MACA, Special Sub-Committee Minutes, 18 June 1924.

²²⁷ WLHUM, MACA, *Annual Report*, 1924, p. 6.

²²⁸ *Ibid.*, 1930, p. 6.

²²⁹ *Ibid.*; WLHUM, MACA, *Annual Report*, 1934, p. 5; WLHUM, MACA, Council Minutes, 6 February 1929; WLHUM, MACA, Scrap Books, 'After Care in Mental Cases: Formation of Local Association', *Oxford Times* (October 1926).

Association's services was that access to voluntary convalescence – like institutional convalescence in purpose-built villas – remained heavily localised. Again, the idealised picture of home-like and sociable half-way homes for convalescence diverged from the experience of the many patients who had no access to the Association's cottage homes through their local authority. While the Cobb and Macmillan inquiries had taken a *laissez-faire* approach that called-upon local authorities to provide increasing support for the MACA, during the 1930s other commentators began to question whether decision-making should be invested in local authorities in the first place. Paul Winterton in his journalistic survey of English mental health services *Mending Minds* (1938) perceived widespread frustration with a prevailing system. In particular, he attacked the centralisation of the MACA and its homes in just a few areas, and mental hospitals' indifference and inaction in making use of the services the Association provided. His conclusion that a 'very strong case' existed for placing mental and general healthcare under central government management suggested that systemic inequalities in service provision could only be remedied by a more coordinated approach.²³⁰ In 1936, the Child Guidance Council and NCMH had reached a similar conclusion, and instigated a non-official committee under Lord Feversham to consider prospects for closer coordination between mental health charities. Reporting in 1939, the Feversham Committee concluded that regional inconsistencies in the availability of mental health charity necessitated the immediate amalgamation of the four largest bodies, including the MACA.²³¹ The BoC agreed, calling for the 'union, or at least... co-ordination' of charities

²³⁰ Winterton, *Mending Minds*, pp. 173-4, 231-3.

²³¹ *Report of the Feversham Committee*, p. 226.

to reduce geographical inequalities in patients' access to voluntary support.²³²

From the outset, the MACA reacted hesitantly and to some extent hostilely to the Feversham Committee's frame of reference. It remained staunchly committed to organisational independence throughout the 1930s, and declared its intention to maintain a 'watching brief' over developments, indicating the sense of its own exteriority to the Committee's deliberations.²³³ In November 1938 Ethel Vickers congratulated the MACA's chairman, Henry Yellowlees for leading 'our attack on that Committee so splendidly', indicating the Association's combative attitude to reform by this stage.²³⁴ The MACA recognised the limited geographical spread of its services in the public and draft statements it produced to explain its rejection of the Committee's proposed reforms. It showed greater concern, however, to avoid what it repeatedly denigrated as the 'bureaucratic system' that it forecast would result from amalgamation. This was based at least partially on a particular vision of aftercare (including convalescence) that privileged the interpersonal bond between charity-worker and recipient. The Association deployed a variety of other arguments in defence of its determined unilateralism, indicating perhaps some degree of organisational pride as well as principled therapeutic intent behind its decision. These included the charity's claims to historical pre-eminence, and its assertions that it retained control of a discreet remit, which in the latter case the Feversham Committee overtly

²³² Ibid., p. 9; David Anderson and Irene Anderson, *The Development of the Voluntary Movement in Mental Health* (London: MIND, c.1982), p. 6.

²³³ WLHUM, MACA, *Annual Report*, 1937, p. 6; WLHUM, MACA, Council Minutes, 2 July 1937.

²³⁴ WLHUM, MACA, Feversham Committee Correspondence, E.D. Vickers to Henry Yellowlees, 18 November 1938.

questioned.²³⁵ Inter-charity rivalry may also have played a part, as evidenced in MACA members' earlier unflattering description of the CAMW's workers as 'busybodies'.²³⁶ At the same time, however, the MACA's claim that its charitable independence allowed it to provide a 'personal touch' to patients under its care resonated with the charity's earlier emphasis on sociability and interpersonal kindness in convalescence.²³⁷ Through the deployment of this argument, the MACA chose to prioritise the quality of care over quantity or ease of access, based on a particular vision of the social work it provided.

The insular approach of the MACA to national coordination in the 1930s offered a rival grassroots vision of aftercare charity to the root-and-branch reforms the Feversham Committee advocated. Attempts at charity coordination were at least as old as the MACA itself, notably exemplified in the efforts of the Charity Organisation Society (COS: 1869).²³⁸ In the 1910s the MACA's Secretary had drawn attention to the MACA's use of the COS's central registration office to avoid overlapping charity, indicating some sensitivity to the deservingness of its recipients.²³⁹ The Feversham Committee's investigations, however, pushed the MACA further into explaining not only the degree of inter-charity coordination, but also the extent of national coverage. Forced to prioritise its objectives, the MACA chose micro-level thoroughness over macro-level comprehensiveness. In its final statement rejecting amalgamation, the MACA unapologetically stood by its tendency to 'view its problems as more private and personal than public

²³⁵ *Report of the Feversham Committee*, pp. 102-3.

²³⁶ [Dr. Worth, cited in:] WLHUM, MACA, Special Sub-Committee Minutes, n.d., c.1930.

²³⁷ WLHUM, MACA, Council Minutes, 16 December 1938.

²³⁸ Prochaska, *Voluntary Impulse*, p. 70; Lewis, *Voluntary Sector, the State, and Social Work*, p. 5.

²³⁹ WLHUM, MACA, Roxby, 'Aftercare for the Recovered Insane' p. 2.

and national'. This statement confirmed a native localism and committed amateurism discernible across the charity's activities, from its *laissez-faire* approach to branch formation to its rejection of formal training in social work in favour of practical experience.²⁴⁰ The debates of the 1930s cast a new light on the MACA's priorities in its practice of mental convalescence and aftercare, which had burgeoned numerically and financially in the preceding years, yet never attained full national coverage. Having placed the onus on regional voluntary action in the 1920s and 30s, the MACA ultimately prioritised a personal form of one-to-one charity over the nation-wide yet bureaucratic system proposed in the *Feversham Report*.

As a result of the MACA's commitment to independence, aftercare remained highly localised, even whilst other areas of voluntary activity became more coordinated. Out of the *Feversham Report*, the National Association for Mental Health (1942) began to offer a nationally-coordinated system of hostels for the mentally handicapped and holiday homes for mental hospital in-patients. By 1947, they also ran two convalescent homes for epileptics, yet omitted convalescent services for mentally ill patients.²⁴¹ Consequently, the *Feversham Report* had little direct impact upon the practice of mental convalescence in England. This continued to rely upon the local availability and accessibility of convalescent homes through independent charities such as the MACA, and the enthusiasm of local

²⁴⁰ The MACA rejected earlier invitations from the CAMW to participate in the organisation of formal social work qualifications. At the meeting at which the MACA declined to take part, Dr Whitwell had stated that 'with regard to training we should consider 6 months actual experience, as of infinitely greater value than the 6 months' course [*sic*] proposed by the C.A.M.W.' WLHUM, MACA, 19 March 1931.

²⁴¹ Thomson, *Problem of Mental Deficiency*, pp. 273-4; Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health* (London and New York: Routledge, 2006), pp. 84, 98.

authorities for the services they offered. In 1954, Kathleen Jones identified significant inequalities in aftercare provision between the various county borough and council health divisions. Whilst she found some 'enthusiastic', Jones noted that aftercare at others was 'non-existent'.²⁴² Given the widespread use that mental hospitals in London and the home counties made of the MACA prior to 1939, it seems likely that voluntary convalescence remained highly localised due to the concentration of homes in certain areas.

Even so, by the time Jones was writing in 1954, it also seems that convalescence as a practice was itself in decline. Whereas use of the MACA's homes had risen consistently between the wars, its chairman in 1954 would identify a decline in demand for convalescent services.²⁴³ It appears from the MACA's more recent publicity sheets that its homes had increasingly grown in size and been turned over to chronic cases, as Chapter One has indicated often occurred to convalescent blocks in nineteenth-century asylums.²⁴⁴ Further dedicated work is required into the changing practice of recovery after the Second World War, yet for whatever reason, it does appear that convalescence may have declined in popularity as a concept of psychiatric recovery. Its usage in psychiatric articles similarly declined after 1945: permutations of the term 'convalescence' in the *JMS* fell from 136 citations in the 1920s, and 140 in the 1930s, to just 47 in the 1950s.²⁴⁵ Just as the idea of early care convalescence had developed in the

²⁴² Kathleen Jones, 'Problems of Mental After-Care in Lancashire', *Sociological Review* 2:1 (1954), pp. 38, 51.

²⁴³ Long, 'Public Representations of Mental Illness', p. 193.

²⁴⁴ WLHUM, MACA, Publicity Sheets, [n.d.: c.1970-80s], p. 4.

²⁴⁵ This is based on an electronic search of the digitised journal, <http://bjp.rcpsych.org> viewed on 19 January 2010.

early twentieth century, so it appears newer concepts may have emerged after 1945 to take its place. The evidence of the *JMS* and MACA hints that other terms such as rehabilitation may have replaced ideas of convalescence, as John Welshman has found at the Brentwood Centre for Mothers and Children in the 1940s.²⁴⁶ By the 1980s, the MACA's publicity described the charity's continuous redefinition of its role 'in the light of changing developments in the field of rehabilitation', in a statement which reflected a semantic shift away from convalescence, whilst hinting at its replacement by other approaches to recovery.

5. Metropolitan Aftercare: The London County Council and the Mental After-Care Association

The evidence of the MACA's administrative centralisation, concentration of its cottage homes in the south-east, and reliance on LCC funding all point to a particular bias of organised voluntary convalescence on London. With the notable exception of localised arrangements in areas such as Somerset and Sussex, the majority of outsourced residential convalescence came through the MACA, which in turn maintained particularly close relations with the LCC.²⁴⁷ Successive interwar chairmen of the MACA highlighted the closeness of the relationship it had forged with London's local authority, raising questions over the LCC's influence on voluntary convalescence in

²⁴⁶ John Welshman, 'Recuperation, Rehabilitation and the Residential Option: The Brentwood Centre for Mothers and Children', *Twentieth Century British History* **19** (December 2008), p. 509.

²⁴⁷ Roof, *Voluntary Societies and Social Policy*, pp. 116-9; Jones, *Mental Health and Social Policy*, p. 106.

this period.²⁴⁸ This section accordingly examines the nature of this relationship between these bodies, and the extent to which new developments in voluntary convalescence emerged through mutual collaboration. Historians of both metropolitan and medical history have considered the LCC an exceptional authority in its commitment to the development of new approaches to healthcare.²⁴⁹ This literature, however, has largely focused on municipal hospital provision, rather than outsourced care of the type the MACA provided. Thus Charles Webster has largely based his contention that the LCC in the 1930s had the aim of 'excluding or marginalizing voluntary agencies' in healthcare provision using the partial evidence of hospital services.²⁵⁰ In contrast, Jane Lewis has argued that far from seeking to sideline volunteerism, interwar commentators unanimously agreed that social work belonged in the voluntary rather than the public sector.²⁵¹ Certainly the LCC gave the MACA significant financial and practical support between the wars and regularly praised the charity's efforts in council minutes.²⁵² Less immediately apparent than the LCC's outward support, however, and the subject of this section, is the degree to which

²⁴⁸ Reginald Worth, (Letters) 'The Social Worker in the Mental Hospital', *Lancet* (30 September 1933), p. 776; WLHUM, MACA, Newspaper Cuttings, Henry Yellowlees, 'Mental Health', *The Times*, 10 June 1943.

²⁴⁹ Powell, 'An Expanding Service', p. 338; John Stewart, "'The Finest Municipal Hospital Service in the World?': Contemporary Perceptions of the London County Council's Hospital Provision, 1929-39', *Urban History* 32:2 (2005), pp. 330-4, 342; W. Eric Jackson, *Achievement: A Short History of the London County Council* (London: Longmans, Green and Co, 1965), p. 25; John Sheldrake, 'The LCC Hospital Service', in Andrew Saint (ed.), *Politics and the People of London: The London County Council, 1889-1965* (London and Ronceverte, WV: Hambledon, 1989), p. 188.

²⁵⁰ Charles Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History* 1 (June 1990), p. 127.

²⁵¹ Lewis, *Voluntary Sector, the State, and Social Work*, p. 92.

²⁵² *London County Council Minutes of Proceedings* (London: London County Council, 1923), 15 April 1925, p. 545; WLHUM, MACA, Council Minute Resolutions, [Alfred A.O. Goodrich, LCC General Purposes Sub-Committee member, speaking on behalf of Claybury and the LCC], 15 April 1925; LMA, LCC, General Purposes Sub-Committee Minutes, 9 December 1930; LMA, LCC, Mental Hospital Committee, Presented Papers, report by R.H. Curtis (Chief Officer) on Public Health Congress, 18 December 1934, p. 5.

support resulted from the LCC's own involvement in shaping the sort of aftercare the MACA provided.

Challenging Charles Webster's view of interwar Labour local authorities such as the post-1934 LCC, Mathew Thomson and Jane Lewis have argued that the public and philanthropic sectors developed a symbiotic reliance upon one another to supply different aspects of mental health care.²⁵³ The MACA increasingly depended upon the LCC's financial support, while the LCC in turn benefited from outsourced charitable services. In October 1919, London's council authorised its mental hospitals to reimburse the MACA's costs for trial cases, and then subsequently enforced subsidisation at a set rate in 1926.²⁵⁴ Early care and voluntary / temporary patients were funded in the same way after 1931.²⁵⁵ This meant ratepayers increasingly contributed indirectly to the basic costs of convalescent treatment, whilst leaving the labour and administration involved in sourcing homes and supervising patients primarily to the voluntary sector. From 1932, the LCC further extended its financial support through annual block grants to the MACA of up to £600 through its Mental Hospitals Committee. These grants provided explicitly for services actually rendered to London patients, calculated through an annual audit of the MACA's accounts, and deducted from other forms of direct payment provided through the Council such as

²⁵³ Thomson, *Problem of Mental Deficiency*, pp. 155-6; Lewis, *Voluntary Sector, the State, and Social Work*, p. 15; Webster, 'Conflict and Consensus', p. 127.

²⁵⁴ WLHUM, MACA, Council Minutes, letter from H.F. Keene (Chief Officer, LCC Mental Hospitals Committee) to Secretary of the MACA, 14 November 1919; LMA, LCC, Minutes of Proceedings, 2 February 1926, 20 July 1926; LMA, LCC, Mental Hospital Committee, Presented Papers, report of General Purposes Sub-Committee (15 March 1938), 22 March 1938.

²⁵⁵ 'After-Care for Voluntary or Temporary Patients', *British Medical Journal* (22 August 1931), p. 356; LMA, LCC, Committee Minutes of Special Sub-Committees, 18 June 1931, p. 237.

individual maintenance grants. Two-thirds of these funds were intended for patients discharged through reception orders, with the remainder allocated to those previously subsidised through the Poor Law before the Local Government Act (1929).²⁵⁶ This gave the LCC a larger financial stake in its patients' community-based convalescence, at the same time allowing the MACA to cover the actual costs of treatment. The MACA often approached the LCC for further funding, which indicates its receptiveness to subsidisation that ultimately supported its ongoing diversification and expansion. At the same time, the Mental Hospital Committee felt the costs 'very reasonable' and proved receptive to such appeals.²⁵⁷

In a period of stagnant or falling philanthropic income (see Figure 15), the MACA increasingly depended upon the LCC to support its activities, whilst the LCC recognised its convalescence as a relatively cheap long-term option for care. Maintenance grants paid to the MACA for convalescence were calculated to cover food, lodgings, clothing and travel, plus 5s to cover the charity's administrative costs.²⁵⁸ The Association itself frequently underlined the cost-effectiveness of its treatment, pointing to the low cost of its overheads, and the prudent prophylactic benefits aftercare presented authorities for avoiding future relapse and the costs of subsequent

²⁵⁶ LMA, LCC, General Purposes Sub-Committee, Minutes, 15 November 1932; LMA, LCC, Mental Hospitals Committee, Presented Papers, report by R.H. Curtis, 'Mental After Care Association', 13 December 1932, pp. 1-2; LMA, LCC, Presented Papers, report by R.H. Curtis (Chief Officer, LCC Mental Hospitals Committee), 'Mental After Care Association', 22 October 1935.

²⁵⁷ LMA, LCC, Mental Hospital Committee, Minutes, Mental Treatment Act Sub-Committee report (7 May and 18 June 1931), 23 June 1931, p. 537.

²⁵⁸ LMA, LCC, Mental Hospitals Committee, Presented Papers, report of General Purposes Sub-Committee (15 March 1938), 22 March 1938.

treatment.²⁵⁹ Discharged, voluntary and temporary cases were not the legal liability of the LCC's Mental Health Department, while maintenance payments to trial cases were optional, so convalescence represented an additional expense. Nevertheless, individuals within the Council interpreted voluntary convalescence as a long-term saving on public finances. Public Assistance Committee payments of £197 15s were made to the MACA for convalescence during 1932. These had been authorised following the opinion of its chief officer, Sir Alan Powell that uncertified patients kept in cottage homes would otherwise be eligible for public relief, and therefore came under the auspices of his department. Though his department would in each case make contributions, Powell supported the MACA's attempts to find work for patients and restore them to rate-paying independence.²⁶⁰ When the Mental Hospital Committee took over these payments in 1933, its Chief Officer took a very similar view, declaring that 'without doubt' the Association provided for patients who would otherwise fall onto public assistance.²⁶¹ The LCC was notably generous in its support of the MACA, yet as these comments attest, also perceived economic advantages to outsourcing the convalescence of those it hoped would soon recommence independent lives.

In practice, despite some support for council-run aftercare, the LCC relied on the MACA for community-based convalescence, and worked closely with the charity in devising new arrangements. The LCC's Mental Treatment Act Sub-Committee collectively felt in 1930 that the Council

²⁵⁹ E.g., [Lord Meath et al.] 'The Mental After Care Association', *The Times* (Thursday 14 December 19 1922), p. 14, **43214**, col. A; [R. Percy Smith, cited in:] 'Charity Meeting: The Mental After Care Association', *The Times* (Friday 30 March 1928), p. 9, **44855**, col. F.

²⁶⁰ WLHUM, MACA, Council Minutes, report of Economy Sub-Committee, n.d. (c. 1931-2); WLHUM, MACA, Annual Report, 1932, p. 6.

²⁶¹ LMA, LCC, Mental Hospitals Committee, Presented Papers, report by R.H. Curtis (Chief Officer), 'Mental After Care Association', 13 December 1932.

'cannot do better' than use the MACA for aftercare, although it significantly left open the possibility of 'alternative means'.²⁶² Further discussions of the Sub-Committee discounted the administration of aftercare directly through the Council, because it felt it could not compete with the standard of the MACA's services.²⁶³ Instead, the LCC formalised its involvement in the MACA's administration, whilst developing a consultative relationship in the formulation of new areas of convalescence, such as early care and vocational employment. A few LCC Superintendents such as Robert Armstrong-Jones and J.R. Lord had already independently become involved in the MACA's administration during the 1910s and 1920s.²⁶⁴ The Mental Hospital Committee's chief officer, H.F. Keene became involved on the charity's Propaganda Committee by the mid-1920s, and was elected to its Council in 1927 before resigning from the LCC in the same year. His offer to resign his place on the MACA's Council upon leaving the LCC suggests that he regarded his role had been at least partly as representing the interests of the Council.²⁶⁵ Following the Mental Treatment Act, the LCC decided it was 'necessary' to gain representation on the MACA's governing Council, which it achieved on the invitation of the charity in July 1931.²⁶⁶ Attendance records for the MACA's Council indicate that LCC representatives such as J.M.

²⁶² LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee, Minutes, report of Mental Treatment Act Sub-Committee, 9 December 1930, p. 395.

²⁶³ Ibid., 17 February 1931, p. 446.

²⁶⁴ Both men were involved on the MACA's Trial Sub-Committee in 1913, and spoke on various occasions at its annual meetings. See 'The After-Care Association', *Journal of Mental Science* **61** (April 1914), p. 343; Jones, 'The After-Care Association'; Jones, 'The Urgent Necessity'; Bond, 'After-Care in Cases of Mental Disorder', p. 284; 'The Mental After-Care Association', *Journal of Mental Science* **75** (April 1929), pp. 349-50.

²⁶⁵ WLHUM, MACA, Propaganda Committee Minutes, 19 November 1926; WLHUM, MACA, Council Minutes, 10 February 1927, 26 July 1927.

²⁶⁶ LMA, LCC, Mental Hospitals Committee, Minutes of Special Sub-Committees, 5 February 1931, p. 200; LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee, 21 April 1931, 12 May 1931; LMA, LCC, Minutes of Proceedings, 19 May 1931, p. 1093.

Oakey and W.D. Nicol regularly participated in meetings after 1931.²⁶⁷ Their nomination of LCC members to the MACA formalised the existing ties between these bodies, and consolidated the LCC's place at the heart of decision-making over voluntary convalescence.

A large proportion of the cases handled through the MACA were referred and funded through the LCC, which gave the authority an unusually large stake in its management. The MACA itself recognised that a 'considerable number of cases with which the Association has to deal, belong to the County of London', and were sufficiently numerous for it to seek financial recompense from the LCC's Public Assistance Committee for these cases.²⁶⁸ In 1937 alone, the LCC referred 498 patients to the MACA's 'convalescent homes and private care'. It is likely that this figure included a number of unimproved cases boarded-out through the Association since 1933, as well as the first holiday patients sent for a temporary break from mental hospitals from 1937.²⁶⁹ Even so, allowing that the 1,012 convalescents and holiday patients the MACA handled in 1937 did not include boarded-out cases, the LCC's referrals evidently formed a substantial part of the total.²⁷⁰ Pressure from the LCC in 1931 for representation on the MACA's Council suggests the LCC increasingly sought more control over decision-making. While the MACA actively petitioned the LCC to financially support the patients maintained on its behalf, London's local authority

²⁶⁷ H.F. Keene had attended four meetings between 1925-9, but after his retirement from the LCC attended twelve meetings in one year alone (1930). WLHUM, MACA, SA/MAC/C.2/2/1, Council Attendance Book, 1925-38.

²⁶⁸ WLHUM, MACA, Council Minutes, report of Economy Sub-Committee, n.d. (c. 1931-2); WLHUM, MACA, *Annual Report*, 1932, p. 6.

²⁶⁹ LMA, LCC, 18.7 (1), *Annual Report*, 1937, p. 30.

²⁷⁰ This figure for the MACA comprised 305 early care patients, 424 aftercare convalescents, 78 voluntary or temporary convalescent patients, and 212 holiday patients. The MACA did not include figures for boarded-out cases. WLHUM, MACA, *Annual Report*, 1937, p. 3.

responded by negotiating lower maintenance rates during the Depression. This prompted the MACA to write to cottage home matrons to reduce the rates they charged patients, which in turn may have affected the level of 'comforts' they were able to provide their convalescents.²⁷¹ The LCC further increased its oversight of the charity's activities in 1932 when it started auditing the MACA's accounts to assess its annual block grant contribution. Such interventions reflected the LCC's expectation that the charity should be accountable for the support it provided, in the investment of both patients and finances for their support.

Efforts to find work matched to patients interests begun in the late 1930s resulted from the MACA's response to an earlier LCC initiative. From 1935, two voluntary patients at the LCC's St Ebba's (formerly Ewell) Hospital became the subjects for an experimental scheme of vocational training, later extended to several other patients.²⁷² It seems that the LCC may then have taken the initiative in asking the MACA to help in finding employment, and was certainly directly involved in shaping the proposal. In 1938, the MACA's chairman suggested that the charity should approach the LCC's chief officer 'before agreeing to take on employment finding'.²⁷³ An introduction by Ethel Vickers to the pamphlet produced to detail the scheme in 1940 further indicates the charity had consulted with the LCC's chief officer, St Ebba's medical superintendent 'and others of wide experience' before deciding to proceed.²⁷⁴ Vickers's description, however, framed the MACA's involvement

²⁷¹ WLHUM, MACA, Council Minute Resolutions, 16 September 1931.

²⁷² LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee, Minutes, 16 July 1935, 19 January 1937.

²⁷³ WLHUM, MACA, Council Minutes, 4 November 1938.

²⁷⁴ MRC, Association of Psychiatric Social Workers, Vickers, 'Foreword', in Laurie, *Employable or Unemployable?*, p. 1.

in this work as the logical development of the earlier 'sympathetic and wise advice' its matrons and hosts offered at its convalescent homes and independent clinics. She argued vocational employment support provided 'expert help in obtaining *really* suitable employment' that prevented patients from a future recurrence of mental illness. This situated the work within the charity's own historical narrative, yet the impetus for this work seems to have stemmed to a large extent from within one LCC mental hospital. It was St Ebba's that described its tailored employment-finding as 'rehabilitation', which was only afterwards offered as part of the MACA's voluntary aftercare.²⁷⁵ Whereas the MACA had complained in the late nineteenth century that medical superintendents often disregarded its community-based activities, by the late 1930s it appears the LCC's mental hospitals and social workers had started to take the initiative in developing socially-situated forms of recuperation.

When a fresh departure in the MACA's work was contemplated, the charity usually consulted with the LCC. These meetings directly implicated the LCC in the development of convalescence for new cases, and indicate the extent to which prolonged trial (1925), early care and voluntary patient convalescence (1931) depended upon the LCC's input.²⁷⁶ Local authority medical staff had always maintained some degree of control over the convalescence of individual trial patients, whose referral and recall depended upon their medical judgement. Through periodical reports, extended to prolonged trial cases in 1925, LCC superintendents also indirectly

²⁷⁵ LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee, Minutes, 19 January 1937.

²⁷⁶ WLHUM, MACA, Propaganda Sub-Committee, Minutes, 23 October 1925; LMA, LCC, Mental Hospitals Committee, Minutes of Special Sub-Committee, 7 May 1931.

supervised their progress.²⁷⁷ Furthermore, guidelines produced by the LCC in 1926 on the care of trial patients indicate that it set policy on the nature of their treatment whilst in the community. These included instructions on the kindness it expected to be shown to patients, and details of daily regimen, which it felt should include a plain diet and regular routine that incorporated some degree of work. Whilst the MACA's work with trial patients enlarged its responsibilities over these patients at an earlier stage in their convalescence, these guidelines also indicate the LCC's interest and involvement in their therapeutic management.²⁷⁸ Occasionally, LCC representatives became directly involved in the inspection of homes intended for a new class of patients. In 1931 the MACA asked the LCC's medical officers to inspect the homes it had prospectively identified for early care convalescents.²⁷⁹ The same sort of involvement recurred in 1938, when the LCC reported on five homes for holiday patients.²⁸⁰ This evidence suggests that the LCC became directly involved in the process of assessing new sites of convalescence and temporary community treatment, not only through representation on the charity's Council, but also through direct visitation.

In the absence of alternatives to certified asylum admission until 1923, the MACA's cottage homes offered a secondary and outsourced means of providing patients with less stigmatised community-based care.²⁸¹ Chapter

²⁷⁷ LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee, Minutes, 17 November 1925.

²⁷⁸ *Ibid.*, 19 January 1926.

²⁷⁹ WLHUM, MACA, Council Minutes, 5 March 1931.

²⁸⁰ *Ibid.*, 1 July 1938.

²⁸¹ This was the Maudsley Hospital, opened in 1923 under the provisions of the London County Council (Parks etc...) Act, and on the terms of Henry Maudsley's bequest of £30,000 for a hospital that would receive acute early cases of mental disorder and fulfil research and teaching functions. See Edgar Jones, Shahina Rahman, and Robin Woolven, 'The Maudsley Hospital: Design and Strategic Direction, 1923-1939', *Medical History* 51 (July 2007), pp. 357-8, 371, 375.

Two has contested David Cochrane's thesis that the LCC's 'metropolitan building spree' resulted from a commitment to asylum treatment; instead it has suggested that the authority actively contemplated alternatives that placed recoverable patients outside the asylum system.²⁸² In 1899, for instance, the LCC's Accommodation Sub-Committee reported that 'by its legal methods of procedure the State places a stigma on mental disease which... is an effectual barrier to the patient applying for treatment in the earlier stages of the disease'.²⁸³ With the sole exception of the Maudsley Hospital opened in 1923, however, its efforts to secure legal sanction for reception houses and voluntary treatment failed. Until the 1930 Mental Treatment Act offered at least the hope that mental hospitals might contribute to the early treatment of voluntarily admitted patients, voluntary convalescence offered an option for the removal of recoverable patients outside the stigmatised asylum. The LCC's use of voluntary cottage homes, like its development of asylum convalescent villas, might therefore be seen as part of the same modernising tendency, which had its roots in the nineteenth century. Three of the four metropolitan asylums had already utilised the Association's services by the time the LCC was formed in 1889, and the majority of the charity's patients in the 1900s came from London.²⁸⁴ A close working relationship therefore already existed between the LCC and the MACA in the nineteenth century, which developed further over the early twentieth century and necessarily took the place of the LCC's other

²⁸² David Cochrane, "'Humane, Economical, and Medically Wise": The LCC as Administrators of Victorian Lunacy Policy', in W.F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III: The Asylum and its Psychiatry* (London and New York: Routledge, 1988), p. 266.

²⁸³ LMA, LCC, Asylums Committee, LCC/MIN/710, Accommodation Sub-Committee Minutes, pp. 91-2, report, 5 July 1899, p. 2.

²⁸⁴ WLHUM, MACA, *Annual Report*, 1887-8, p. 5; WLHUM, MACA, 'Rough but Detailed Notes from Four Scrapbooks', p. 13.

proposals for the improved treatment of the most recoverable mentally disordered individuals under its jurisdiction.

Madeline Roof's emphasis on the closeness of relations between the LCC and MACA tends to obscure dissenting voices within the local authority prepared to consider mental convalescence as a duty of local government.²⁸⁵ The idea that the LCC should itself undertake aftercare was taken seriously enough for a motion to be put to the Council in 1929 asking for £500 to promote legal reforms to make this possible. While the motion was defeated, more than a third of members voted in favour (33:62), including John Speakman, future chairman of the Mental Hospitals Committee, and George Gibson, General Secretary of the National Asylum Workers' Union.²⁸⁶ The MACA's Council recorded that the proposal had been 'heavily defeated', yet a substantial minority of the LCC's Council had in fact actively supported direct and proactive action to wrest control of aftercare from the voluntary sector.²⁸⁷ The Mental Treatment Act, 1930, made it possible for the LCC and other authorities to fund aftercare, which led most (including the LCC) to subsidise the MACA. A report produced on US and Canadian mental hospitals in 1930 by A.A.W. Petrie (Medical Superintendent, Banstead) nevertheless again demonstrated the willingness of some within the LCC to contemplate placing aftercare further under local authority control. Petrie directly compared the English reliance on the MACA, with the New York and New England systems of state-run aftercare services, concluding that both systems had 'some advantages'. Reflecting his own vantage as a medical

²⁸⁵ Roof, *Voluntary Societies and Social Policy*, p. 118.

²⁸⁶ Speakman was elected to the chairmanship in 1937. Gibson established the National Asylum Workers' Union in 1910. LMA, LCC, Council Minute Proceedings, pp. 526-7.

²⁸⁷ WLHUM, MACA, Council Minutes, 1 May 1929.

superintendent, however, Petrie felt state-run services held particular benefits for bringing hospitals 'into closer touch' with the related problems of aftercare and social prevention.²⁸⁸ Far from there being a consensus, it therefore appears that members within the LCC disagreed over the retention of aftercare under voluntary management and promoted an enlarged role for local government in convalescence.

Before the Mental Treatment Act, the LCC had apparently relied upon the MACA to provide community-based services that (with the anomalous exception of the Maudsley Hospital) remained outside its legal powers. From the Act's implementation on 1 January 1931, however, the LCC and other local authorities obtained the option to provide or fund aftercare directly. A letter sent to the BoC in 1935 expressed the LCC's keenness to utilise its powers over aftercare to the 'fullest possible extent', which became evident in the development of its own services, as well as its ongoing support for the MACA.²⁸⁹ Already by July 1931 the Mental Treatment Act Sub-Committee had proposed the acquisition of a property for the Maudsley Hospital which, 'with small adaptation, could be used for accommodation of... convalescent and minor cases'. This was apparently an isolated idea, perhaps reflective more of the Maudsley's unusual position at the heart of a south-London community where it was less practicable to build onsite convalescent villas. Yet the idea alone is significant, because it indicates some at least within the LCC's Mental Hospitals Committee considered placing under local authority

²⁸⁸ LMA, LCC, Presented Papers, A.A.W. Petrie, report on visit to US and Canadian mental hospitals, and arrangements for early treatment, June 1930, p. 2.

²⁸⁹ TNA, BoC, Correspondence Files, 'Mental Treatment Act: After-care', memorandum, Mr Leaming (LCC Mental Hospitals Department) to BoC, 14 May 1935.

management the sort of ordinary community-based dwellings the MACA ran as cottage homes.²⁹⁰

More subtly, the appointment of psychiatric social workers at four of the LCC's mental hospitals between 1931 and 1934 increasingly brought a wider problem of social restitution directly under the control of LCC staff. Unlike the earlier appointment of a charitable social visitor at Horton Hospital in 1922, psychiatric social workers were professionally trained, and directly employed by the LCC.²⁹¹ Reports of social workers employed directly by the LCC after 1931 suggest a greater departure from the sort of convalescence the MACA had provided, and a rival vision of recovery. D.R. Montfort, social worker at Banstead, prepared a statement in c.1933, in which she explicitly contrasted her work with the convalescent home care voluntary organisations had long offered. In her vision of recovery, patients' restitution to health depended upon 'integrating the various family interests into a harmonious whole, without stopping short at any particular aspect of it'. Seeing the problem as one of ongoing psychological 'social maladjustment', Montfort's report implied that recovery depended upon permanent behavioural and environmental changes, not the temporary break afforded by convalescence.²⁹² Social workers certainly referred a small number of patients to the MACA at the request of medical superintendents. Once referred to the MACA, social workers discontinued their involvement with cases, providing some delineation between their areas of activity. The report

²⁹⁰ LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee, report of Mental Treatment Act Sub-Committee (9 July 1931), 14 July 1931.

²⁹¹ J.R. Lord, *Social Workers and the Insane* (London: Allard and Son and West Newman, 1923), p. 24.

²⁹² LMA, LCC, Mental Hospitals Committee, Presented Papers, D.R. Montfort (Psychiatric Social Worker, Banstead Mental Hospital, LCC), 'The Uses of a Trained Social Workers Stationed at a Mental Hospital', n.d. (c.1933), pp. 1-2, 18 July 1933.

of another social worker, however, proudly recorded that the 'majority' re-adjusted through her mediation between patient, family and environment, suggesting social work provided an alternative rather than complement to convalescence.²⁹³ At the same time as the LCC supported the MACA's convalescent work, it also therefore pioneered an alternative model that targeted the problem of readjustment *in situ*, rather than temporarily removing patients to a more idyllic yet artificial convalescent existence.

6. Conclusion

The mixed membership of the MACA, and the competing visions of other charities, had always provided scope for contested interpretations of convalescence. Speakers at the MACA's meetings identified cottage homes with a diverse range of impediments to recovery, including individual behaviours and (im)moralities, defective interpersonal relationships, and wider environmental problems such as housing and unsuitable work. Henry Hawkins's founding concerns with social conditions remained at the core of the MACA's work in the 1930s, albeit with less emphasis on morality, as the charity sought to provide a more conducive space for recovery than they believed existed in the world beyond. This represented a tacit indictment not only of the social conditions in which the working-class had to live, but also of the failure of mental hospitals to promote sustainable health amongst their patients. Medical superintendents participated hesitantly in the MACA's activities during the nineteenth century, though the involvement of some

²⁹³ At Ewell, 15 out of 229 patients (6.6 per cent) handled by the resident social worker between 1 October 1931 and 31 May 1933 were subsequently referred to the MACA. Ibid., 'D. Lilley (Psychiatric Social Worker, Ewell Mental Hospital, LCC), 'Report of Social Worker for the Period 1.10.31 to 31.5.33', p. 3, 18 July 1933.

indicates the connection between psychiatry and community care significantly preceded the broader structural shifts of the mid-twentieth century. More widespread medical support for the MACA from the 1900s appears to have coincided with greater psychiatric interest in prevention. Superintendents assumed a large role in planning for the delegation of trial care to the charity in 1913, which gave it an enlarged role over patients considered psychiatrically as well as socially 'convalescent'. In turn, during the 1920s and 1930s the LCC in particular invested time in meetings with the MACA and money into new voluntary and community-based initiatives such as early care convalescence. This provided the charity with a larger number and broader spectrum of 'convalescents', thereby expanding both the concept of convalescence and the boundaries of its practice.

Cottage homes provided an increasingly diverse profile of early care, aftercare, ex-service, voluntary and temporary 'convalescent' patients with an apparently normal, yet necessarily artificial and constructed site for recovery. Outwardly, these homes presented few distinguishable or remarkable features, which mirrored their function as sites of seclusion and protection that anticipated convalescents' returns to homes of their own. To some extent, the location, dimensions and management of homes depended upon the responses the charity received from would-be matrons. However, decisions taken at a central level on their scale and situation, and perhaps more importantly their day-to-day management as quasi-familial spaces, necessarily made them mediated, controlled, and therefore artificial sites for recovery. It is these evaluations of cottage homes that perhaps reveal most about what residential convalescence was intended to achieve, and

consequently, why convalescence itself was practised. An emphasis in the MACA's administrative records on homeliness and the concomitant values of comfort, good diet and kindness identified cottage homes as protective, but also enjoyable sites of temporary treatment. Psychiatric convalescence, like physical convalescence, seems therefore to have been descriptively aligned with the temporary restorative function of a holiday, albeit one with a more explicitly therapeutic purpose.²⁹⁴ To some extent the MACA's incorporated a more utilitarian intention to prepare patients for a future life of activity and productivity. As Chapter Four demonstrates, convalescents were also prepared mentally in homes to contemplate their future working lives. More indirectly, the sale of mental hospital patients' occupational therapy manufactures provided an annual boost to its income, which the charity had commenced with the LCC in 1922 so that patients 'would thus feel that they are helping the work... by which many of them come to benefit'.²⁹⁵ Yet these homes mainly seem to have offered patients a brief and restful hiatus between institutionalisation and their restitution to an industrious role in the wider economy. Paradoxically, the calm and comfort cottage homes offered purposefully removed patients from the 'normality' and complexity of community life in a state of suspension, deferring full reengagement with challenging social and environmental conditions until a later date.

Numerical and financial growth in the MACA's activities seems to have largely coincided with a period of diversification and innovation, which brought convalescence to a broader range and number of patients. Together

²⁹⁴ Cronin, 'Scottish Convalescent Homes', pp. 223-7.

²⁹⁵ LMA, LCC, Asylums and Mental Deficiency Committee, Presented Papers, memorandum from E.D. Vickers (MACA) to H.F. Keene (LCC Asylums and Mental Deficiency Committee), 26 July 1922.

with the development of convalescent villas within many public mental hospitals, this expansion of voluntary accommodation brought psychiatric convalescence into the reach of many more rate-assisted patients by 1939 than had access in 1919. Nevertheless, convalescence across England remained highly localised, concentrated principally around London and the south-east, and other areas such as Yorkshire that supported active local branches. Elsewhere, Bristol's utilisation of the BBMHS's homes, and Brighton C.B. Mental Hospital's connections with the Guardianship Society made a virtue of systemic localism, by keeping patients in close contact with their own community. Official, medical and lay commentators increasingly placed pressure on the MACA through the 1920s and 1930s – as the central provider of psychiatric convalescence – for more national and universal access to the services it provided. Ultimately, however, the MACA prioritised one-to-one care-giving over a larger coordinated but potentially bureaucratic and impersonal organisation. This perhaps mirrored the charity's therapeutic emphasis on interpersonal support, and smaller-scaled and less institutional homes in its own practice of convalescence. Even so, through increasing direct payments and closer involvement in new initiatives, local authorities also began to assimilate convalescence into their own institutional practices. Cottage home convalescence in the voluntary sector was therefore often part of an integrated system of rate-assisted medicine, in which the public authorities funded both placement in mental hospital villas, and later voluntary cottage homes. Publically-underwritten community services that had previously been restricted to convalescent 'trial' patients were subsequently extended before 1939 to incipient and chronic cases, in a way

that appears to have anticipated a more general post-war shift to public community care.

The London County Council had (with Bristol) one of the most coordinated systems of public and voluntary psychiatric convalescence in England between the wars. The LCC and MACA's relationship perhaps exemplifies the sort of 'cooperative convergence' that Geoffrey Finlayson has argued often defined the relationship between interwar charities and the state.²⁹⁶ Cooperation between these bodies in the arrangements for such new areas of convalescent provision as early care and the rehabilitative area of vocational employment-finding rested on mutual benefits that enabled each to function more effectively. Thus, the MACA gained considerable financial security and advocacy through the LCC's support, whilst it supported the LCC's efforts to develop new forms of occupational and community-based care. Nevertheless, there are also signs that a significant minority of the LCC's members may have wanted to replace voluntary support with an in-house system of local authority aftercare. This was raised in the *Feversham Report* in 1939, which suggested that local authorities often took over charities' earlier pioneering efforts once these had demonstrated a need, although the report assumed authorities were generally unwilling without legal compulsion.²⁹⁷ So too, the development of psychiatric social work offered a competing psychological vision of recovery at odds with the MACA's emphasis on convalescence. Like the Guardianship Society, psychiatric social workers appointed in all of the LCC's hospitals by 1936 suggested that a temporary period of psychiatric convalescence might

²⁹⁶ Finlayson, 'A Moving Frontier', p. 199.

²⁹⁷ *Report of the Feversham Committee*, p. 47.

not accurately reflect or address patients' longer-term need for psychological readjustment. The MACA's continual growth and close-working with the LCC throughout the 1930s, however, suggests it largely retained this authority's backing, and that moreover, the LCC had often helped shape its approach to convalescence.

Chapter Four: Patient Responses to Convalescence, 1910–39

1. Introduction

Previous chapters have suggested that convalescent villas within mental hospitals, and voluntary cottage homes in the community, made the abstract notion of convalescence more tangibly visible in bricks and mortar between the wars. Such homes fixed the notion of convalescence within recognisably familial and home-like milieus, and in turn identified their patient-residents as ‘convalescents’ on the borderland between sickness and health. After 1919 in particular, local authority and voluntary providers increasingly worked together to extend convalescence into the community. This chapter explores how far those defined by these spaces as convalescents accepted this label, and responded to these efforts that aimed to bridge a gap in their treatment between institutionalised illness, and socialised sanity. It analyses patients’ descriptions of their time under care, and adherence to behavioural expectations, in order to assess how far patients maintained their own perspectives on what it meant to be convalescent. As this chapter will explore, patients responded to their treatment in various ways, through their utterances, actions and written accounts. These responses provide an important – and as Roy Porter has noted sometimes jarringly critical – counter-narrative to professional claims made for mental treatment.¹ Despite a growing engagement with patient perspectives in asylum history, Susan Lanzoni has argued it remains under-researched, partly because there are

¹ Roy Porter (ed.), *The Faber Book of Madness* (London and Boston: Faber and Faber, 1991), p. 350.

fewer available sources.² This chapter addresses patient attitudes, and reflects upon what organisational and autobiographical sources can reveal about convalescents' sense of memory, identity and belonging, during a recuperative phase otherwise organised and assessed by others.

Several historians have taken up the claim that historians should take lunatics' accounts seriously, and look beyond the sites and therapies created for the mentally ill to patients' own perspectives on their treatment.³ The sources available to historians, however, present interpretive issues and to some extent serve to marginalise the rate-assisted patient. Anthologies provide a useful source on changing attitudes over time, yet have also tended to draw preponderantly upon published accounts by relatively literate, educated and therefore often middle-class autobiographers.⁴ Unlike in Scotland, the Board of Control in England sanctioned the routine destruction of patient letters on their asylum treatment.⁵ Where letters have survived, as at Gloucester and later at Morningside in Scotland, historians such as Allan Beveridge and Leonard Smith have demonstrated their potential to reveal an otherwise largely hidden history of emotional responses amongst pauper patients and their families.⁶ This chapter builds on the work of others, therefore, who have begun to explore patient perspectives on medical classification and class in twentieth-century asylum regimes, and extends

² Susan Lanzoni, 'The Asylum in Context: An Essay Review', *Journal of the History of Medicine and Allied Sciences* **60**:4 (2005), p. 505.

³ Dale Peterson (ed.), *A Mad People's History of Madness* (Pittsburgh: University of Pittsburgh Press, 1982), p. xiii; Allan Ingram (ed.), *Voices of Madness* (Stroud, Gloucestershire: Sutton, 1997), p. xiv; Allan Beveridge, 'Life in the Asylum: Patients' Letters from Morningside, 1873-1908', *History of Psychiatry* **9** (December 1998), p. 461.

⁴ Peterson (ed.), *A Mad People's History of Madness*; Roy Porter (ed.), *Faber Book of Madness* (London and Boston: Faber and Faber, 1991); Ingram (ed.), *Voices of Madness*.

⁵ Beveridge, 'Life in the Asylum', p. 434.

⁶ Leonard Smith, "'Your Very Thankful Inmate": Discovering the Patients of an Early County Lunatic Asylum', *Social History of Medicine* **21**:2 (2008), p. 238; Beveridge, 'Life in the Asylum', p. 462.

this into the interwar period. Due to strict closure periods that protect patient confidentiality, this thesis draws upon those of the MACA's case records over eighty-four years old in addition to further case data gleaned from other records. These predominantly relate to the period before 1925 covered in case-files, and after 1931 when the MACA's annual reports began to quote extracts from selected patients' letters. In most cases these records mediated the voice of the patient through the secondary interpretations of the charity's workers. Consequently, this chapter concentrates on selectively-recorded patient *responses* to convalescence, rather than more complete patient *accounts*.

Collectively, these sources illustrate patients' reinterpretations and outright rejections of a convalescent identity, as well as more conventional thankfulness for their treatment. These sources suggest something specific about convalescence, rather than the collective 'patient's view' addressed in previous studies. As such, it assesses a particular patient view: that of prognosis and recovery. This explores the attitudes and reactions of those on the margins of a 'patient' identity, whose liminal position allowed them to situate themselves in relation to both hospital and home. The majority of case-records offer only minimal data on the progression of patients that obscures their vocal, mental and volitional responses to their convalescence, whilst even more detailed cases are routinely mediated through the records of case-workers. Nevertheless, the patient responses assessed in this chapter suggest that convalescent patients may have responded in a variety of ways to their treatment. The approach taken draws upon the ideas of Erving Goffman and Joel Braslow, who have suggested that asylum

convalescence encouraged compliant behaviour amongst those patients aspiring to asylum discharge.⁷ Extended to the community, this chapter proposes that the idea of convalescence provided patients with a means to comprehend their recoveries, which resulted in not only compliance, but self-reflection. Though their choices over how they described their recovery – whether they accepted, rejected or reinterpreted convalescence within personal narratives – patients consciously or unconsciously made sense of their place in society.

The first section of this chapter considers methodological and evidential parameters that guide the subsequent analysis. This assesses biases in record creation and survival, and the sort of information collected and commemorated in provider and patient accounts. Section two draws upon these conclusions to assess how patients may have incorporated convalescence into personal narratives of recovery, or, alternatively, perceived their mental health in other ways. This appraises the existence of a collective convalescent identity formed between patients and its vitality as a popular social concept. Section three discusses agency and belonging, and patient identification with particular sites at different stages in their treatment. It analyses patients' diverse actions and appeals to consider how far recipients shared the view of the architects of convalescence that it represented a 'halfway home' for the protection, and promotion, of their incipient mental health.

⁷ Erving Goffman, *Asylums: Essays on the Social Situations of Mental Patients and other Inmates* (London: Penguin, 1991 [1961]), pp. 121, 150; Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley, CA, and London: University of California Press, 1997), p. 28.

2. Marginal Voices: Evidential and Methodological Issues

Patient accounts and responses at once illustrate individual perspectives, and suggest collective attitudes to convalescence. Anthologies of patient accounts embody this tension between the personal and the shared. Roy Porter has introduced *The Faber Book of Madness* as a 'rich miscellany' that represents a 'spectrum of experiences', yet has also headed themed chapters with selective generalisations that connect many accounts.⁸

Similarly, this chapter does not presuppose a single 'patient's view', offset against those official and voluntary perspectives examined in previous chapters. Instead, like Porter, it surveys the themes that link patients' otherwise diverse experiences during their treatment and accommodation as 'convalescents'. Patients framed their recoveries in different ways, and responded individually to attempts to manage this process. Some patients accepted the idea that they required convalescence, such as Lillian T, who wrote from Cane Hill Asylum in 1914 that she wished to go to a convalescent home.⁹ In contrast, fellow inmate at Cane Hill John R, eschewed the term in a 124 page plea for discharge sent to the MACA in 1915. Instead John R recalled how he had earlier 'recovered immediately', and was 'perfectly sane', and consequently emphasised a simple binary between sickness and recovery, which entirely elided the idea of convalescence.¹⁰ Patients also responded to the convalescence offered to them in different ways; some like Lillian T actively sought out treatment, whilst others escaped from cottage

⁸ Porter, *The Faber Book of Madness*, pp. xii-xiii.

⁹ Wellcome Library for the History and Understanding of Medicine [WLHUM], Mental After-Care Association [MACA], MACA SA/MAC/G.3, Case Files, 4077 (Lillian T), 24 November 1914.

¹⁰ WLHUM, Case Files, (John R), letter from John R (Patient, Cane Hill Asylum), sent 18 July 1915, p. 35.

homes or rejected care offered to them in other ways. Nevertheless, themes of acceptance and rejection, escape and belonging permeate many of the patient responses examined in this chapter. The responses studied affirm Allan Beveridge's claim that there are 'frequent similarities' between patient responses to treatment, which, if not monolithic, nevertheless attest to some shared perspectives between recipients.¹¹

The most detailed records on patient responses are the 32 case-files currently available for the period between 1888 and 1925, which cover all the Association's aftercare activities, including cottage home convalescence. This small extant sample represents a tiny fraction of the patients treated through the Association in this period; in 1924 alone, the charity handled 1,176 aftercare cases (including 351 convalescents).¹² The detail and contextualisation for each case provided in these files, however, makes them a valuable, if potentially unrepresentative source, especially given that they provide relatively rare evidence on pauper patients' experiences during treatment. They are particularly revealing about patient's lives before and after admission; information Jonathan Andrews has argued is generally lacking from asylum case-notes.¹³ Detailed correspondence survives in only one of these files: that of Alice T, covering the period 1916–24. This provides a unique glimpse into the priorities and compromises negotiated between one patient, the MACA, employers, and cottage home managers, in an attempt to restore the patient to sanity and an active social role. These letters

¹¹ Beveridge, 'Life in the Asylum', p. 461.

¹² Madeline Roof, *Voluntary Societies and Social Policy* (London and Kegan Paul, 1957), pp. 96-7, 119.

¹³ Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine* 11 (June 1998), p. 263.

between different parties situated Alice T's treatment at the nexus of medical, voluntary, social and personal interests in recovery. It is harder from such case-specific evidence, however, to ascertain representativeness or extrapolate more broadly on patient attitudes to convalescence.¹⁴ In other files, caseworkers overlaid their own secondary interpretation, variously summarising correspondents as 'sarcastic' and 'annoyed' in ways that tacitly highlighted their involvement as mediators in the charitable relationship.¹⁵ These summaries lack the ambivalences evident in Alice T's case, where the different parties seem to have vacillated between affection and annoyance, despair and dutifulness. Nevertheless, they contain significant detail on a small proportion of cases across a broad period: usually several months and sometimes years.

Record linkages with contemporary case-registers situate these fragmentary surviving case-files into the broader context of 1,418 convalescents helped through the Association.¹⁶ There is limited evidence that the MACA hand-picked those case-files that have survived for posterity. Some of these simply refused help to patients, whilst others are imperfectly preserved, including one case where the patient's history is partially obscured by pages from a contemporary annual report pasted over the top.¹⁷ Record linkage with the case registers suggests that their survival is more likely attributable to the use they served for ongoing case-management. Two of the files relate to the Association's response when convalescent patients

¹⁴ WLHUM, MACA, Case Files, 5109 (Alice T).

¹⁵ 4065 (Geoffrey H), 18 June 1914; 5241 (Jessie C), 8 April 1921.

¹⁶ These patients were assessed by the MACA during 1910, 1914, 1918, 1920, 1922, 1924. In addition, this chapter also assesses other interesting cases for these years, and 1919, 1921, 1923 and 1925 (to July). Andrews, 'Insanity at Gartnavel', p. 264.

¹⁷ WLHUM, MACA, Case Files, 4417 (Ellen Margaret R.)

ran away.¹⁸ Others related to unusual entries in the register dealing with cases discharged from prison, referred to other agencies, and sent to a sailor's home. Such cases appear relatively exceptional, compared with the standard formula 'convalesced, closed and initialled' placed next to most entries. The relatively high survival of case-files with unusual circumstances perhaps suggests these records served as precedents for future decision-making. However, the presence of empty files and the grouping of files in certain years suggest their survival was to some extent random.¹⁹ While these records contain primary biases in the individual case-worker's account of events, it therefore seems less likely that these files were themselves premeditatedly selected. Registers indicate that the MACA provided convalescence for those who ultimately committed suicide, and those referred for domestic abuse, for which files have not survived. Such cases appear rare, though it is possible the registers under-recorded their frequency. More statistically significant, the case-files perhaps over-represent other atypical cases, and, as a result, obscure the experience of the majority. Most register entries simply recorded patients' acceptance into cottage homes, and occasionally financial contributions towards their maintenance. The responses of these patients are especially difficult to ascertain from the available evidence.

Registers therefore suggest something about the representativeness of the extant case-files as a whole, as well as into individual case histories. Annual reports after 1931 recorded extracts from patient letters, which

¹⁸ There were only four such cases recorded in the register for the ten years analysed in detail for this chapter: 1910, 1914, 1918-25

¹⁹ Half of the files between 1888-1925 dated from 1914: sixteen of thirty-two.

provide a further useful source for a period when registers and files remain closed. These extracts almost universally recorded patients' and relatives' thankfulness for the care the MACA had arranged. As selected and edited fragments intended for an audience of potential supporters, these reveal little about patients' collective views of the MACA, or the range of letters and patient responses the MACA might have received. Given the apparent bias in the case files towards relatively unusual or problematic cases, however, they do provide limited evidence on those who apparently passed their convalescence uneventfully and successfully. Their accounts contrast with the dissatisfactions among several case-file subjects, which itself suggests the diversity in patient responses to convalescence. A comparison of these sources consequently sheds light upon the potential typicality of the extant case-files, so they are at least partially comprehensible within the context of the MACA's total caseload.²⁰ Annual reports encapsulate how patients may have subsequently imagined and explained their treatment, which is harder to deduce from primary case records. Within the trope of the thank-you letter recorded selectively in these reports, patients frequently looked back upon their care in certain ways, whether as a holiday, refuge or convalescence. Their descriptions elaborated on the reasons they had received care, and its benefits to their health, within a retrospective personal narrative. As such, they usefully indicate how patients may have accounted for their 'convalescence' with hindsight, within an ongoing biographical narrative, rather than the medical encounter documented within case-records.

²⁰ Bill Luckin, 'Towards a Social History of Institutionalization', *Social History* 8 (January 1983), p. 89.

Autobiographies and letters typically captured patient attitudes at a few fixed points in time at most, in contrast to regularly-updated case-notes, which recorded a continually varying picture of patient responses. The Association's case-workers summarised patient observations on their treatment, and often responded to patients as multifaceted and complex personalities. In one instance case-notes even recorded the comments of a patient's *alter ego*, couched in inverted commas, which served to distinguish it from the primary voice of the named patient.²¹ The Association's secretary regularly sought to persuade, encourage and reason with patients who reacted negatively to their convalescence or employment. Such attentiveness to patient feelings and expressions of identity distinguish the charity's aftercare case-notes from asylum notes, which Andrews and Smith have argued in the nineteenth century typically ignored patient responses beneath an overlaid psychiatric narrative.²² Livia Velpry has similarly argued that psychiatric staffs tend to privilege those patient testimonies consonant with their professional interpretations.²³ In contrast, it appears the MACA considered patient emotionality a significant barometer of patient wellbeing and personality, and consequently recorded patient dissent. While annual reports reproduced only positive patients accounts, often centred on 'happiness', case records often documented more negative patient responses, albeit sometimes with a critical authorial eye. These files reveal much about convalescents' changing personal feelings towards matrons and subsequent employers, and their actions in leaving and returning to cottage

²¹ WLHUM, MACA, Case Files, 4993 (Kathleen O), 10 August 1917 to 11 January 1918.

²² Andrews, 'Life at Gartnavel', pp. 259, 263-6; Smith, 'Your Very Thankful Inmate', p. 238.

²³ Livia Velpry, 'The Patient's View: Issues of Theory and Practice', *Cultures of Medical Psychiatry* 32 (2008), pp. 241-5.

homes. Some emotional responses may have remained hidden or unquestioned by the charity's workers. Interpersonal relationships between convalescents and sexual identities, for example, are largely absent from case-records that documented the individual patient, and their internal adjustment to domestic and work environments.

Most of the records utilised in this chapter structured patients' disclosures in some way and utilised them as part of a broader record. Carol Berkenkotter has used John Haslam's *Illustrations of Madness* (1810) to suggest how psychiatric case-histories recontextualise patients' 'reported speech' within a medicalised frame. The MACA's case-histories similarly regarded patients' letters from the psychiatric case-worker's perspective, and summarised their views as part of a case-history designed to document their progress to recovery. Likewise, patient testimonies in annual reports served a rhetorical function and recorded patients' normatively 'sane' thankfulness with their earlier 'insane' resistance or reluctance. Unlike Haslam's broadside, however, the MACA's case-histories were regularly updated, and because of this ongoing contingency at the time of their authorship, present a less overtly polemical source on patient attitudes.²⁴ They share more in common therefore with the Ticehurst case-histories as examples of what Berkenkotter has interpreted as 'narrativised accounts'. Such accounts, Berkenkotter has argued, utilised patients' reported speech to evidence their progress and regression, and justify their ongoing treatment.²⁵ Patient letter summaries in the MACA's case-files similarly demonstrated reasons for

²⁴ Carol Berkenkotter, *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry* (Columbia, SC: University of South Carolina Press, 2008), chapter 2.

²⁵ *Ibid.*, p. 99.

providing patients ongoing support, and evidenced the case-worker's diligent watchfulness and responsiveness. The MACA's case-files nevertheless present a more multi-vocal source than Berkenkotter's psychiatric case-histories, which present a simple dialectic between authoritative psychiatric narration and subordinated patient voice. Boards of guardians, cottage home proprietors and relatives were among those third parties whose evaluations appeared in the MACA's various case-files. Together, these presented a more contested interpretation on the patient's illness, prognosis, behaviour and attitudes. Structurally, the MACA's case-files shared the chronological progression of Ticehurst's registers, which in each case recorded help given and problems encountered. In their content, however, the MACA's files incorporated multiple perspectives, albeit selectively based on the case-workers' interpretation of their relevance.

The MACA's files occasionally reflect case-workers' input into their narrative structure, and suggests their inherent bias as authored accounts. Miss Wells's introductory case-histories of Elizabeth C and Elizabeth F highlight the role such workers performed as investigators and interpreters. In 1910, Wells noted that while Elizabeth C 'answered... questions quite intelligently', she also 'obviously resented being questioned'. This draws attention to a line of questioning that Wells followed to elicit information, and the secondary interpretive judgements she applied to what Elizabeth C said. In contrast, the previous year Wells had described how Elizabeth F 'spoke freely and willingly of her past but was quite averse to having her former lodgings visited', indicating the environmental dimension to her investigations. Non-verbal cues such as facial expressions were similarly

recorded and interpreted as evidence of patient's underlying character. Wells considered the uncooperative Elizabeth C's countenance 'sulky and defiant', but commented more approvingly of Elizabeth F's 'nice appearance'.²⁶ Original patient letters would provide a less mediated source, but because in most cases only case-workers' summaries survive, these are also likely to have been read and judged for their informational significance.²⁷ This is indicated in assessments made upon patient's tone. In several instances, the MACA recorded that patients 'seemed' variously 'happy', 'grateful', or 'upset' from their letters.²⁸ Comparing Alice T's surviving correspondence with other letters reported in case-files, it appears that while the latter recorded points requiring action and occasionally extraneous information, they necessarily omitted much detail on patients themselves. While in one case the case-worker chose to record that the patient was related to a 'champion billiards player', letter summaries rarely recorded the complex emotions and reasoning evident in Alice T's letters.

The editorial excisions and summaries that made up case-histories consequently compromise their veracity as historical records of patients' lived experience. What remains is a composite record that only selectively recorded small parts of patient responses, sometimes according to questions that the charity itself had asked. Autobiographies used in this chapter introduce more detailed and unmediated sources on patient attitudes, and permit an exploration into the mixed feelings patients may have experienced

²⁶ WLHUM, MACA, Case Files, (Elizabeth Frances Charlotte C), 11 October 1910; 4192 (Elizabeth F), 15/17 February 1915.

²⁷ Gunter B. Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine* 5 (June 1992), pp. 186-7.

²⁸ WLHUM, MACA, Case Files, 4049 (Florence H); 4897 (Edith Vere E) 1 August 1915; 4993 (Kathleen O), 12/13 March 1917.

during their recoveries. Marian King and William Seabrook's autobiographies exemplify the detachment patients may have initially felt towards other convalescents on having to leave friends in other wards behind. Their emotional responses, however, were quite different; while King's emphasised the 'queer sensation' and loss this move brought, Seabrook highlighted the relationships he formed with patients on other wards.²⁹ Accounts such as theirs shift attention from planners' intentions to patients' experiences, as Kerry Davies has argued, and, like the MACA's case records, illustrate the diversity and variability of patient perspectives both individually and collectively.³⁰ In contrast to case-files, however, which focused particularly on individual patient histories, autobiographies provide greater evidence on the extent to which shared spaces fostered a sense of collective convalescent identity. Together with the patient letters recorded in the MACA's annual reports, these autobiographies indicate the importance of sociability and privacy to patients during their recoveries. Autobiographies therefore reflect personal accounts on recovery, but also ideas on belonging shaped through the input of other patients and carers within institutions, and those with an interest in their care in the wider community. Furthermore, the ideas on recovery they present form part of a narrative consciously set forth for a public audience. This viewed recovery retrospectively, within a teleological

²⁹ Marian King, *The Recovery of Myself: A Patient's Experience in a Hospital for Mental Illness* (New Haven: Yale University Press, 1931); William Seabrook, *Asylum* (London: George G. Harrap, 1935).

³⁰ Kerry Elisabeth Davies, 'Narratives Beyond the Walls: Patients' Experiences of Mental Health and Illness in Oxfordshire since 1948' (unpublished PhD thesis, Oxford Brookes University, 2002), p. 96.

and typically final narrative, which lacks some of the contingency and uncertainty convalescents displayed within case-file records.³¹

The 'retrospective readjustment and rationalization' that Allan Beveridge has argued distorts memoirists' tone, also provides a useful insight into the ways in which patients subsequently made sense of their experiences.³² They indicate how patients as writers sought to reconcile their illness, troubles or convalescence with their subsequent life. The direct address some autobiographers made to their readership betrayed the public nature of this reconciliation, and the extent to which they framed their experiences for a wider audience. Marion King's question 'can you understand that my heart sank?' spoke directly to a readership who she assumed were unfamiliar with the emotions she might have felt.³³

Meanwhile, Rachel Grant-Smith's production of both a book, and articles in the periodical *Truth* (which were reproduced in her book), indicate the particular efforts she made to document her case, when most recovered patients published nothing.³⁴ Their elective use of terms such as 'convalescence' and 'recovery', in autobiographies and in the letters reproduced in the MACA's annual reports, indicate the how these patients framed their past, and their return to wider society to themselves. But they also wrote these accounts for a public readership, and are accordingly likely to have envisioned their recoveries in ways meaningful to a wider social

³¹ Porter, *The Faber Book of Madness*, p. 519.

³² Beveridge, 'Life in the Asylum', p. 461.

³³ King, *Recovery of Myself*, p. 83.

³⁴ Rachel Grant-Smith, *The Experiences of an Asylum Patient* (London: George Allen and Unwin, 1922), pp. 9, and appendices.

audience.³⁵ Some authors emphasised resistance rather than recovery, which provided a social incentive to publish their work, in the form of critiques against a defective asylum system they had witnessed firsthand. Thus, while Grant-Smith called for better classification and legislation to make voluntary treatment possible, Mary Riggall concentrated on a 'great reform' of qualitative aspects such as food and entertainment, and entirely separate treatment for borderline cases.³⁶

The act of public remembrance therefore distinguished autobiographers from others who maintained only a private memory of their former treatment. These patients were not only 'survivors', as Roy Porter has claimed, but a subset within this survivor group who had chosen to document their recoveries.³⁷ Necessarily unrepresented are others without the means to publish, who chose to forget, or through relapse or suicide after convalescence were unable to provide an account of recovery. It is important therefore to consider the silence of the majority alongside the utterances of the few. The anonymity authors afforded to other patients stood in marked contrast to their own willingness to be identified.³⁸ Various personal agendas motivated patients to recount their experiences. Some like Mary Riggall openly introduced their intention to stimulate public interest in asylum reform, or like Mary Grant-Smith with its introduction by Montagu Lomax, presented a polemical case for voluntary treatment.³⁹ In contrast, others such as Marian

³⁵ Stefan Machler and Moira Moehler-Woods, 'Wilkomirski the Victim: Individual Remembering as Social Interaction and Public Event', *History and Memory* 13 (Fall/ Winter 2001), p. 83.

³⁶ Grant-Smith, *Experiences*, pp. 42, 71; Mary Riggall, *Reminiscences of a Stay in a Mental Hospital* (London: Arthur H. Stockwell, 1929), pp. 5-7.

³⁷ Porter, *Faber Book of Madness*, p. 519.

³⁸ Jayson, *Mania*, p. 7; Riggall, *Reminiscences*, p. 4.

³⁹ Riggall, *Reminiscences*, p. 5; Grant-Smith, *Experiences of an Asylum Patient*, pp. 42, 71.

King and Lawrence Jayson contextualised their experiences much more personally, as an improvement in mental health, and, most strikingly, an affirmation of familial relationships and belonging. The differences in tone and agenda evident between these autobiographies indicate authors abstracted different meanings from their experiences. Their diverse responses, however, may still potentially omit other viewpoints, particularly the subtler emotional responses to convalescence evident in reprinted convalescents' letters. Milder feelings of gratitude or dissatisfaction are less likely to have prompted patients to document their recoveries than the strong resentment, relief and jubilation apparent in these published accounts. Residual negative emotions such as shame and regret are similarly absent from the published accounts surveyed in this chapter. Instead, most presented a teleological narrative that accentuated improvement and distanced the author from their former illness.

Retrospective patient accounts and case-records provide a useful insight into the process of framing historical experience. Allan Ingram has identified distinct Nonconformist, legalistic and medical preoccupations in mad-peoples' narratives before 1808.⁴⁰ The richness found in such extended autobiographical testimony is significantly lessened in edited and mediated case-records. Kathleen O's case-file suggests she may have been more concerned at times with spiritual absolution than medical or social restitution, yet the file paid more attention to the latter. Case workers in this case paid more attention to her *alter ego* and her behaviour during convalescence than her copious writings, which were frequently mentioned without reference to

⁴⁰ Ingram, *Voices of Madness*, pp. xv, xvii.

their content. This subordinated Kathleen O's voice within the case record to the medical and social concerns of her assessors.⁴¹ Historians should therefore consider the institutional and vocational contexts in which case-workers classified patients, and seek to understand their priorities and omissions. Case-records, like cottage homes and villas, provided form to the sub-acute, and therefore otherwise invisible notion of convalescence. The spaces created for convalescence explored in previous chapters embodied a particular vision of recovery, which residents may not have necessarily shared. The meaning of classifications such as convalescence depended, as Ian Hacking has argued, upon whether and in what ways patients applied it to their own condition.⁴² Case records require particularly sensitive and cautious interpretation to allow for the overlaid interpretations superintendents and charity workers introduced into the record. Autobiography and oral history typically provide greater contextual detail on how patients comprehended their recoveries within their broader life experience. The retrospective process of autobiographical composition, however, also distanced patients from their original memories, whilst case records reveal something about how providers became involved in making sense of the patient's 'convalescence'.

⁴¹ WLHUM, MACA, Case Files, SA/MAC/G.3/1-3,5,8-15,17,28,30-7,40-1, 4993 (Kathleen O).

⁴² Ian Hacking, *The Social Construction of What?* (London and Cambridge, Mass: Harvard University Press, 1999), pp. 31-4.

3. Identity and Remembrance: Patient Representations of Convalescence

While villas and cottage homes nominally identified their residents as 'convalescents', patients after discharge had an opportunity to electively reappraise and rephrase, descriptions of their pathway to social restitution. Some, like Lawrence Jayson and Mary Riggall, identified their improvement with a progression through the ward system. Riggall probably stayed in a convalescent ward in c.1920-21, given that her discharge had occurred eight years before she published *Reminiscences* in 1929. With this degree of hindsight, patients such as Riggall had a choice over where and when they antedated their recoveries, if they did so at all. In Riggall's case, she associated having 'become much better' with her residence in a 'convalescent ward' and thereby affirmed the hospital's own classificatory linkage between this space and wellness.⁴³ Likewise, Lawrence Jayson's account suggests that he and his fellow patients recognised an implicit connection between their place within the ward system and their progress towards discharge. 'The ambition of all patients was to be transferred to the Villa', Jayson claimed in 1938; a building he associated with a final but contingent phase in treatment that provoked 'envy' amongst other patients in the main building. Trusted patients in this villa received parole, and Jayson recalled that patients regarded revocation of this privilege a 'disaster'. Although Jayson made no reference to this block as a convalescent villa, he assigned it a comparably probationary function, when he recorded that transfer here implied a 'steady progression toward complete freedom'.⁴⁴ It seems therefore that some patients retained a positive memory of their

⁴³ Riggall, *Reminiscences*, p. 12.

⁴⁴ Jayson, *Mania*, pp. 109, 191.

convalescence inside mental hospitals, as a period in which their improved health and status amongst patients had been reflected in their advancement through a hierarchical ward system.

The jealousy Jayson recalled amongst non-convalescents towards those whose improvement qualified them for the villa contextualised their attitudes on the basis of his own experience. Those who petitioned for release, however, appear to have often ignored the intermediate stage of convalescence and viewed their health in a binary relationship as either sane or insane. A letter sent from Mary Ann B in Abergavenny Asylum to the LCC in 1922 made no distinction between the different parts of the institution she inhabited. Instead, Mary Ann considered the entire institution a 'tomb' that since 1912 had kept her 'fetterd among the Lambs of England... kept prisoner on facts [*sic*]'. She believed herself 'in full possession of my senses', and therefore asserted an unambiguous wellness, and ability to legitimately determine her right to 'freedom'. This emphasised rationality, rather than provisional recovery, even though the author also admitted 'I struggle to keep my sanity' and therefore alluded to the potentially provisional nature of her wellness.⁴⁵ Others like John R and Hilda P similarly eschewed convalescence and protested their sanity and fitness for release. All these patients rejected institutional treatment on the basis of self-proclaimed sanity. John R referred more than once to his attempts to 'get out' and felt himself 'quite able to fight my own battles' without need of further help.⁴⁶ Hilda P's original statement on her treatment has not survived, but a summary in

⁴⁵ London Metropolitan Archives [LMA], London County Council, LCC/MIN/607-701, Asylums and Mental Deficiency Committee Presented Papers 1920-39, Letter from Mary Ann B to Chairman of London County Hall, 17 August 1922.

⁴⁶ WLHUM, MACA, Patient Files, John R., pp. 2, 86.

hospital minutes likewise indicates her focus remained on discharge rather than recuperative treatment. In Hilda's case, she refuted she had ever been deranged, and therefore viewed her committal as wrongful confinement rather than a recuperative process. Minutes record she 'refused to cooperate for tests that might have led to more parole', suggesting that she rejected the medical basis for an assessment ultimately designed to affirm convalescence.⁴⁷

Steven Cherry and Anne Digby's work has suggested that even in the late eighteenth and early nineteenth century, the placement of convalescent accommodation may have offered an encouragement for patients to strive for wellness.⁴⁸ It seems likely that earlier twentieth-century developments in remotely-situated convalescent units, explored in previous chapters, encouraged some patients to regard convalescence as a more clearly distinct and desirable phase in treatment.⁴⁹ Lawrence Jayson recalled that residents in his old block discussed amongst themselves what Lancing Villa might be like and concluded that they 'would find paradise'.⁵⁰ At a still further remove, cottage homes in the community also became the target for speculation amongst patients who looked forward to their eventual discharge. Relapsed cases who had previously received convalescence, then re-entered mental hospitals would have known more about the

⁴⁷ Devon Record Office [DRO], Devon County Mental Hospital, DCC/147/9 and DCC/154/1/1/1-2, Visiting Committee Minutes 1922-1938, 5 June 1928.

⁴⁸ Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), pp. 66-7; Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum, St Andrew's Hospital, 1810-1998* (Woodbridge and New York: Boydell Press, 2003), pp. 34, 311.

⁴⁹ This also corresponds with Kerry Davies's views on post-1948 patient experiences of mental hospital treatment. She has argued that 'patients used ward differentials to place themselves within the system in relation to others, and to later make sense of their experiences in the form of narratives'. Davies, 'Narratives Beyond the Walls', p. 99.

⁵⁰ Jayson, *Mania*, p. 109.

existence of these homes and helped disseminate an awareness of convalescence beyond the asylum to other patients. A letter sent from MACA case 29172 during convalescence, selectively quoted in the charity's annual report for 1935, recollected that they had learned about its cottage homes from a man in the hospital who claimed 'he had been to about five of these places'. This man's view of these homes as a 'Heaven' is similar to Jayson's account and suggests how relapsed patients may have contributed to other patients' awareness and understanding of what these homes were like.⁵¹ The MACA had strong reasons to select the most favourable patient testimonies for its reports, which publicised its activities to actual and potential benefactors and stakeholders. Nevertheless, the detail in case 29172's statement suggests that patients within mental hospitals to some extent discussed what convalescence might be like, even if privately others potentially held less positive memories.

Relocation within the asylum proved difficult for some convalescents, who continued to identify themselves with friends they had made on other wards. Marion King in particular remembered how her 'heart sank' when she became a parole patient after ten days in the mental hospital, because she 'hated to think of leaving the nurse and my first friend'.⁵² Colin Gale and Robert Howard have found evidence at late nineteenth-century Bethlem of 'a network of communication and friendships among patients', in correspondence sent between two convalescent patients at the hospital's

⁵¹ WLHUM, MACA, SA/MAC/B.1, Annual Reports, 1887-1922, 1924-39, 1935, p. 10.

⁵² King, *Recovery of Myself*, p. 83.

home at Witley.⁵³ King and William Seabrook's autobiographies suggest such networks also in some cases traversed classificatory boundaries, leading to more complex patient identities. Seabrook in his 1935 autobiography on his experiences of an US asylum claimed that during treatment he 'began preferring the company of... the wild men from the back halls to that of my own convalescent playmates'.⁵⁴ How far such associations were possible for patients in English rate-assisted mental hospitals is unclear, given the Board of Control's stipulation that convalescent villas should help separate recoverable patients from others.⁵⁵ Those granted full parole into the outlying community may have had more opportunity for contact with non-convalescents outside the hospital entirely. Even so, King recalled a sense of loss and helplessness that prompted mixed emotions when her progress meant she had to leave behind old friends and make new ones. King and Seabrook's empathy with other classes of patient indicates they identified with personalities rather than classifications, which patients may have felt generally, even if increasing segregation meant it became harder to keep in touch with old acquaintances. It is significant in this context that Seabrook chose the infantile word 'playmates' to describe his fellow convalescents, which represented them as companions imposed upon him by the paternalistic asylum authorities.⁵⁶

Unlike most patients, King, Seabrook and the other memoirists surveyed here chose to document their experiences and feelings for a public

⁵³ Colin Gale and Robert Howard, *Presumed Curable: An Illustrated Casebook of Victorian Psychiatric Patients in Bethlem Hospital* (Paterson, Hants; and Philadelphia: Wrightson Biomedical, 2003), p. 19.

⁵⁴ Seabrook, *Asylum*, p. 215.

⁵⁵ See Chapter Two.

⁵⁶ Seabrook, *Asylum*, p. 215.

audience. It does seem that for some patients, convalescence and the prospect of recovery provided the incentive for patients to document their experiences. Thus, William Seabrook claimed he had decided during his asylum stay that he would 'surely write something' about his experiences when he gained parole privileges, which he felt had led asylum staff to consider him 'changed from convalescent drunkard to inquiring reporter'.⁵⁷ Even in these very public disclosures, former patients recorded their desire to forget aspects of their treatment. H.G. Woodley professed that in writing his book he had 'found it very pleasant... forgetting the past, and dreaming dreams of the future'. Like Seabrook, it was at the point of his release that Woodley recorded the impressions he would take away with him. Within Woodley's retrospective account, these feelings of 'horror, madness, pity, despair, desolation and hopeless' appeared more transient, as he predicted they would 'recede into the distance' with time.⁵⁸ Such potent negative emotions provided a strong incentive for patients to obliterate or sublimate their former mad and convalescent identities. Eric Leed has argued that forgetting became 'essential to recovering a sense of selfhood, stability and sanity' for traumatised patients.⁵⁹ For patients like Woodley, however, distance from the event perhaps made it easier to write and reflect on their experience, summarised in his reflection that the gloom caused by his time in the asylum had 'vanished in the glory of the sunshine of to-day'.⁶⁰

⁵⁷ Ibid., p. 216.

⁵⁸ Woodley, *Certified*, pp. 161, 221.

⁵⁹ Eric Leed, 'Fateful Memories: Industrialized War and Traumatic Neuroses', *Journal of Contemporary History* 35 (January 2000), pp. 86-7.

⁶⁰ This sunshine appears to have been both literal (he claimed to be writing the concluding chapter in his garden) and metaphorical, as a positivity that enabled him to recall his past incarceration. H.G. Woodley, *Certified: An Autobiographical Study* (London: Victor Gollancz, 1947), p. 218.

At the same time, other memoirists alluded to the process forgetting may have played for those who didn't commit their thoughts to print, or who only appeared in print because others republished their utterances and case-histories. Lawrence Jayson noted several patients had opposed his plans to write, 'fearing it might do harm to those who had completely buried those chapters of their lives'.⁶¹ The MACA appears to have sought to facilitate the process of forgetting in some cases. In at least two cases during the 1930s, the MACA wrote how its convalescence had helped patients 'forget' unhappy domestic lives and experiences.⁶² While the charity publicly wrote about the contact many patients chose to maintain with its staff, case-files suggest that more privately workers often welcomed, or at least interpreted benefits, into the fact patients had severed contact. Four years after the last entry in the charity's file on Alice T, the charity received a request on her whereabouts. Without further contact details, the Association's secretary Ethel Vickers concluded that "no news is good news" and Alice did not want to write to us, as she was getting on well'.⁶³ Erasing the past, however, proved difficult for some. Patient 3094 (Mary P), who had been admitted into a MACA cottage home in 1910 and 1914, contacted the Association during 1935 with no hope that her memories would fade. 'I shall never all my life forget how I was rambling on', this patient wrote, though like Woodley and other memoirists, she drew a clear distinction between her mad self and 'all that I am and have to-day'.⁶⁴ Personal reinvention and return to a sane sense of self allowed

⁶¹ Jayson, *Mania*, p. 7.

⁶² WLHUM, MACA, *Annual Report*, 1933 (case 24520, p. 14), MACA, *Annual Reports*, 1937 (case 33151, p. 13).

⁶³ WLHUM, MACA, Case Files, Alice T, copy letter from Ethel Vickers to Mrs Florence J., 23 October 1923.

⁶⁴ WLHUM, MACA, *Annual Report*, 1935, p. 10.

patients like Mary P to distance themselves from bad experiences, even if they could not entirely forget.

The descriptions employed in patients' letters often recast convalescence into a more recognisable social idiom, which linked recovery to common community experience, and thereby pulled a veil over former mental hospital treatment. Letters that recorded patients' gratitude to the MACA commonly referred to their stay in the Association's cottage homes as a pleasurable break, rather than convalescence. Rebecca H and Alice C both offered thanks for the 'holiday' after their convalescence in the 1910s, which workers summarily noted in their case-files.⁶⁵ From the extracts reproduced in the MACA's annual reports, and a journal feature in the 1930s, it appears patients preferred the term 'holiday' to 'convalescence' when summarising their placement under the charity's matrons.⁶⁶ That so many ex-patients referred to a vacation rather than convalescence indicates that those accommodated for 'convalescence' adopted alternative, less medical, terms to describe their treatment. In turn, the Association after 1931 seems to have been happy to reproduce such extracts that described treatment in other terms besides convalescence. The charity's inclusion of these extracts in its reports publicised a lay rather than medical perspective on the charity's activities. It may have purposely included those letters that substituted terms that the charity's readership could readily relate to and appreciate, in place of the relatively medical term 'convalescence'. After 1937, the MACA also

⁶⁵ WLHUM, MACA, Case Files, 4064 (20 July 1914) and 5031 (25 November 1916).

⁶⁶ WLHUM, MACA, *Annual Reports*, 1931 (case 20072, p. 12), 1934 (case 25713, p. 12), 1935 (case 28613, p. 10), 1937 (cases 1887, 15351, pp. 11, 20); WLHUM, MACA, SA/MAC/H.1/2-5, Press Cuttings from Albums, 1897-1965, cutting of 'Mental After-Care Association: Holding Out the Helping Hand', *The Nursing Mirror and Midwives' Journal* (28 March 1936).

began to offer 'holiday home' places for working mental hospital in-patients, which allowed these patients to consider themselves on holiday from institutional conditions.⁶⁷ In contrast, convalescents occupied spaces that the Association's workers defined according to their medical recuperative function, but which residents often appraised differently. Even so, the alternative terms convalescents used only survive in the historical record because the MACA included them in its case-files and publicity.

It seems, therefore, that many convalescents viewed their stay in cottage homes as a restful and enjoyable break from the homes and communities they would otherwise have returned to upon discharge from mental hospitals. By referring to holidays rather than convalescence, patients presented their treatment as an unremarkable hiatus from social life, whilst downplaying their former illness and institutionalisation. Some directly equated convalescence with the standard working- or middle-class holiday and at the same time downplayed the medical reasons for their stay.⁶⁸ Patient 20072 connected their convalescence with previous holidays they had taken before certification, stating that they had 'not been able to have a holiday like this for many years'.⁶⁹ When Annie H relapsed after convalescence during 1917, she similarly viewed a stay with her sister as a 'fortnight's holiday', after which she felt 'quite well now'.⁷⁰ An ambiguity over what constituted medical supervision, and what represented a recuperative holiday therefore allowed patients to interpret their convalescence socially

⁶⁷ WLHUM, MACA, SA/MAC/C.2/1-3, Council Minutes 1913-15, 1917-20, 1927-31, 8 April and 1 July 1937.

⁶⁸ The patient's own social status is unclear from the report. WLHUM, MACA, *Annual Report*, 1931, p. 12 (case 20072).

⁶⁹ WLHUM, MACA, Annual Report, 1931, p. 12.

⁷⁰ WLHUM, MACA, Case Files, 5001 (20 August 1917).

rather than medically, as something they had chosen and enjoyed. Seaside and countryside lodging houses increasingly became an option for early twentieth-century working-class holidaymakers, though it remained beyond the means of some.⁷¹ Such experiences, and a general association between seaside and holidays, may have predisposed working-class convalescents to view their treatment as a vacation. Patients' identification of their cottage home convalescence as a recuperative holiday mirrored wider interwar concerns with overwork and working-class ill-health, which fed into the debates leading up to the Holidays with Pay Act, 1938.⁷² As such, the MACA's patients envisaged themselves as recipients of necessary rest from the social pressures of work that policymakers would increasingly extend to the working-class population at large.

From the details reproduced in the MACA's reports, it seems many patient letters combined the form and content of both thank-you note and postcard. Patients regularly commented on the quality of the weather, sea air, food, and company, in ways that emphasised the sensory and picturesque aspects of their stay.⁷³ Above all, patients tended to emphasise the 'kindnesses and care they had experienced whilst in cottage homes. The son or daughter of case 22889 asserted the primacy of relationships to their mother's recovery in 1932, when they remarked that her improvement derived 'more so because of the thought and kindness shown to her' than

⁷¹ John Walton, *The British Seaside: Holidays and Resorts in the Twentieth Century* (Manchester and New York: Manchester University Press, 2000), pp. 57-60; Susan Barton, *Working-class Organisations and Popular Tourism, 1840-1970* (Manchester and New York: Manchester University Press, 2005), p. 133.

⁷² Sandra Dawson, 'Working-class Consumers and the Campaign for Holidays with Pay', *British Twentieth Century History* 18:3 (2007), pp. 283-4, 288-9.

⁷³ E.g., WLHUM, MACA, *Annual Report*, 1937, p. 11 (case 1887).

from environmental factors.⁷⁴ Similarly, another patient emphasised the part 'kindness and helpful sympathy' had played in their recovery, which they regarded as more important 'even than material assistance'.⁷⁵ In contrast to memoirists' writings on mental hospital convalescence, which tended to emphasise segregation and status differentials amongst a wider patient community, cottage home residents more often discussed their immediate environment and co-residents. Alice T's file contains a letter that represents the only first-hand and unmediated comment made by a patient in a cottage home in the MACA's files, when she remarked she felt 'very well and happy here', that she had been with others 'for a nice walk', and found it all 'very nice'. Though fleeting, this description compares with other patients cited in the MACA's report that highlighted personal wellbeing, with anecdotal detail on environment and shared activity.⁷⁶ Others chose to mention the 'beautiful' weather and grounds and 'good' food and company they had experienced.⁷⁷ Such observations looked beyond the patient's own interior mental condition, and, much like a holiday postcard, instead highlighted pleasurable externalities.

An emphasis in patients' letters on the enjoyment they had derived from their stay in cottage homes to some extent recast mental convalescence itself as a primarily social rather than medical practice. Certainly recovering patients contested the strictly medical purpose of their placement and contributed to an alternative reading of its purpose as a break from normal life. In this respect, mental convalescents in the early twentieth

⁷⁴ *Ibid.*, 1932 p. 13 (case 22889).

⁷⁵ WLHUM, MACA, Annual Reports, 1935 p. 11 (case 9803).

⁷⁶ WLHUM, MACA, Case Files, Alice T, letter from Alice T to Ethel Vickers (Secretary, MACA), received 23 October 1918.

⁷⁷ WLHUM, MACA, Annual Reports, 1936, pp. 10-11 (case 31669); 1937, p. 11 (case 1887).

century perhaps contributed to a broader reinterpretation of convalescence as little different from holidaymaking. Their representations exemplified Elizabeth Gardiner's claim in 1935 that convalescence occupied an uncertain position between the 'overlapping circles' of medicine and society.⁷⁸ Spas, nervous sanatoria and general convalescent homes occupied a comparably ambiguous position in interwar England. Phyllis Hembry and Jenny Cronin have independently attributed the twentieth-century decline of spas and general convalescent homes to a lack of scientific credibility and an inadequately articulated distinction of their difference in their function from the emergent package holiday.⁷⁹ In contrast, John Stewart has indicated the reliance of successful new movements in interwar psychiatric medicine on claims to scientific method.⁸⁰ That the MACA proved willing to reproduce and publish patient statements that linked convalescence with holidays suggests it endorsed the comparison. When case 32100 described the 'lovely time' they had spent at the voluntary cottage home, they affirmed the benevolence of their care, which to some extent supported the observation and seclusion that previous chapters have argued psychiatrists sought to extend over convalescents.⁸¹ At the same time, however, this emphasis on enjoyment suggested such homes offered little that the increasing numbers able to afford holidays could find elsewhere themselves.

⁷⁸ Elizabeth Greene Gardiner, *Convalescent Care In Great Britain* (Chicago: University of Chicago Press, 1935), p. 9.

⁷⁹ Phyllis Hembry, *British Spas from 1915 to the Present: A Social History* (London: Athlone, 1997), pp. 241-3; Jenny Cronin, 'The Origin and Development of Scottish Convalescent Homes, 1860-1939' (unpublished PhD thesis, University of Glasgow, 2003), pp. 280-5.

⁸⁰ John Stewart, 'The Scientific Claims of British Child Guidance', *British Journal for the History of Science* **43** (September 2009), p. 430-1.

⁸¹ WLHUM, MACA, Annual Report, 1937, pp. 10-11 (case 32100).

To a lesser extent, recipients of convalescence also described the medical advantages it had offered them as patients recovering from mental disorder. Patients variously stated that they felt ‘absolutely fit’, ‘very, very much better’, and ‘in excellent health’ after their convalescence, and consequently emphasised how it had helped sustainably complete their recovery.⁸² Letters sent from patients during their stay in cottage homes also often made reference to the fact they felt ‘much better’, such as Alice C shortly after she had arrived at Burgess Hill for convalescence.⁸³ When paper shortages required the MACA to omit its usual quotes from letters in its 1939 annual report, it summarily emphasised patients’ general ‘delight and appreciation’ for their care, and ‘happy relations’ in its homes.⁸⁴ Such impressions potentially followed a selective reading of patient letters for their positive emotional content, and claims that treatment had benefited convalescents’ mental health. In earlier reports, the MACA highlighted the value of its work for ‘averting relapses and consolidating recoveries’, so it is perhaps unsurprising that the letters it chose to reproduce in its reports also evidenced the overtly medical benefits of convalescence. Even so, from this largely mediated available evidence, it does appear that some patients shared the MACA’s view that convalescence had helped to finalise recovery. These cases typically recorded a mixed assessment of their treatment, which combined an evaluation of the medical and social benefits accrued from their cottage home placement. Patient 32100 recorded the good food and happiness they had enjoyed during their stay, but also stated they felt ‘ever

⁸² WLHUM, MACA, *Annual Reports*, 1931, p. 12 (case 20072); 1934, p. 12 (case 25713).

⁸³ WLHUM, MACA, Case Files, 4080 (Ernest S), 12 October 1914; 4153 (Amy Rose R), 10 and February 1915; 4993 (Kathleen O), 7, 9, 11 and 18-19 December 1917.

⁸⁴ WLHUM, MACA, *Annual Report*, 1939, p. 5.

so much better for the nice change'.⁸⁵ A more overt emphasis on therapy appeared in case 31719's letter, which reported a 'remarkable improvement in my health... derived from my stay at Godalming', though again they also commented upon the generous catering.⁸⁶

Despite these pleasurable associations between convalescence and holidays, a substantial minority of patients and relatives also linked the help they received with less happy memories of former sickness. Patient 9803 blamed 'excessive mental and spiritual strain over thirty years' for their need for the MACA's help. While this patient accentuated the MACA's part in their recovery, it evidently also forced the patient to recall memories of past 'nervous weakness, with fear of mental collapse'. In another case, a medical professional given convalescence in 1936 recorded he had been 'rather losing faith in things when I came here', but felt he had started to regain his 'usual happy outlook'. At the same time, these patients also apparently wanted to situate their convalescence within a greater biographical story, which documented their gradual transformation and improvement.⁸⁷ Each respectively presented nervous strength or happiness as their natural state, which convalescence had helped restore.⁸⁸ While most patients who wrote to the MACA seemed happiest to regard their convalescence as a therapeutic holiday, for others it formed part of a self-affirming personal narrative of

⁸⁵ Ibid., 1937, pp. 10-11 (case 32100).

⁸⁶ Ibid., 1936, p. 10 (case 31719).

⁸⁷ This corresponds with Kerry Davies findings based on oral history interviews with post-1948 mental hospital patients, who, she has suggested, often create 'starting points' in their life- and patient-narratives. These serve, Davies has argued, to distance the patient from an unsatisfactory past (and present) and look most firmly to a hopeful future. See Kerry Davies, "'Silent and Censored Travellers"?: Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine* 14 (June 2001), p. 276.

⁸⁸ WLHUM, MACA, *Annual Reports*, 1935, p. 11 (case 9803); 1936, p. 11 (case 31318).

psychiatric, spiritual or emotional recovery. In 1915, the Association recorded that in addition to 373 fresh applications, they had also dealt with letters or visits by nearly 200 old cases.⁸⁹ While some potentially required practical advice or support, others such as Alice C elected to return. Alice visited the MACA's offices in April 1918, three months after her discharge from Mrs Farrant's home and placement. During this visit, she looked back to her time at Colney Hatch, and credited the Association's support for keeping her out for so long.⁹⁰ For some, therefore, convalescence represented a part of their lives they chose to remember and a positive milestone, which separated them from past insanity and unhappiness.

Alice's case, however, also indicates the contingency with which some patients may have viewed their recoveries, even after discharge from cottage homes. The MACA generally closed case-files after a further period had elapsed, and sometimes after the patient had taken several jobs. For Alice, this meant that although she left the cottage home and began work in January 1918, her case was only marked 'convalesced... closed and initialled' in January 1923.⁹¹ Case-records suggest significant variability in the length of time that patients remained under observation and received support, which is likely to have significantly affected how patients viewed their convalescence and independence.⁹² The charity closed the file on some patients like Jessie C, Pansy P and Jane B between two and four months

⁸⁹ 'The Mental After-Care Association', *Journal of Mental Science* **62** (April 1915), 323-8.

⁹⁰ WLHUM, MACA, Case Files, case 5031, 2 January 1918 and 15 April 1918.

⁹¹ *Ibid.*, 15 April 1918 and 11 January 1923.

⁹² This suggests that in addition to a distinction between short- and long-stay cases within mental hospitals that historians have observed, a further distinction existed between those discharged patients who maintained long-term contact with social service agencies, and those who severed connections relatively rapidly. See Digby, *Madness, Morality and Medicine*, p. 219; Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London and New York: Routledge, 1998),

after their acceptance for cottage home treatment.⁹³ Such short convalescences represented a comparably brief and distinct period out of hospitals and away from home. For cases whose treatment took much longer to conclude, the patient is likely to have viewed their recovery more provisionally. This is perhaps evident in the way Alice, who remained under the MACA's supervision for five years, referred to having stayed out of Colney Hatch 'so long'. Mary P, who had been convalesced at least twice after 1910 and had evidently kept in contact with the Association into the mid-1930s, similarly viewed her improvement hesitantly as an ongoing process. Rather than viewing her recovery as a brief interlude, she wrote how she had 'fought steadily on'. Whilst she distanced herself from her 'rambling' former self, she also acknowledged subsequent relapses, and attributed her present sanity to the 'strength' she had drawn from the MACA over the years.⁹⁴

In some cases re-entry to cottage homes took place on multiple occasions over a lengthy period. During the period surveyed, Louisa Grace L received care in 1910 and again in 1921.⁹⁵ Similarly, Jessie C first entered a cottage home in 1917, and was adjudged fully convalescent within four months, but relapsed and was readmitted to the MACA's care for further convalescence nearly four years later. In both cases, readmission cumulatively extended these patients' experience of illness and convalescence over a much longer period. Jessie's sister-in-law at least

⁹³ WLHUM, MACA, Case Files, case 5241, 27 March 1917 and 26 July 1917; WLHUM, MACA, Agenda Case Books, (cases 7022 and 8545), 12 August and 25 November 1920, 11 November 1922 and 24 January 1923.

⁹⁴ WLHUM, MACA, *Annual Report*, 1935, p. 10 (case 3094).

⁹⁵ WLHUM, MACA, Registers, 3075 (Louisa Grace L), 23 November 1910, 12 May 1921 and 11 January 1923.

questioned whether Jessie would ever become sustainably convalescent, telling Vickers in 1921 that her reliance on drink led her to regard any help 'little use in the end'.⁹⁶ Behind the MACA's deceptively simple metaphor that its convalescence helped 'bridge a gap' between sickness and health, therefore, recurrent cottage home treatment meant that for some patients, convalescence was an episodic rather than a singular experience. It appears that just as nineteenth- and early twentieth-century asylum admissions comprised a notable minority of re-admissions, so cottage homes accepted some convalescents on more than one occasion.⁹⁷ For those such as the general paralytic sent to a mental hospital convalescent villa in the mid-1920s, and reported in 1935, convalescence represented the start rather than the end of a complex series of relocations. In this case, the patient subsequently returned to her mother, went 'elsewhere' for eight years, before she went into a different mental hospital in 1935. W.D. Nicol, the mental hospital superintendent who had convalesced the patient several years before, felt she was better physically but otherwise 'quite inaccessible'. Like Jessie C's sister-in-law, Nicol held out less hope for permanent recovery for patients who had once convalesced and since relapsed. He concluded that

⁹⁶ WLHUM, MACA, Case Files, 5241 (Jessie C), 12 April 1921.

⁹⁷ The different experiences of recovery held by those who subsequently relapsed, and those who recovered (or at least received no further institutional treatment) is apparent both in recent work on ex-servicemen, and on civilian psychiatry. See Mary Fisher, "'Getting Out of the Asylum": Discharge and Decarceration Issues in Asylum History' (unpublished PhD thesis, University of East Anglia, 2003), p. 9; Anne Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', in Jonathan Andrews and Anne Digby (eds), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004), pp. 228-9; Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (Basingstoke: Palgrave Macmillan, 2002), pp. 134-6, 155-6.

whilst the prospects of general paralytics had improved, examples such as this suggested prognosis remained 'disappointing'.⁹⁸

It seems likely, therefore, that patients' understandings of convalescence, and their identification with the concept, may have varied according to their different personal institutional careers. Relapses and readmissions created discontinuities, which tacitly challenged the sustainability and permanence of recovery, and for some patients potentially led them to re-evaluate whether 'convalescence' best described their experience. The powers vested in medical superintendents and visiting committees over patient discharge and trial leave allowed them to decide at what point patient became reached a stage of convalescence.⁹⁹

Superintendents regularly authorised whether and when patients might receive convalescence within their own institutions and the MACA's voluntary homes. To the MACA, they often acted as both referrers and assessors on the Association's Council. Case files frequently betray superintendents' input into the expedition, deferment or rejection of cases for convalescence. For instance, while Dr Ogilvy petitioned the MACA to accept one case he claimed was insane although 'technically' a criminal, superintendents on other occasions countermanded convalescence for nominated patients.¹⁰⁰

Maurice Craig, consultant psychiatrist and the Association's treasurer (1921–29), argued in *Psychological Medicine* (1905, 1926) that the decision over

⁹⁸ W.D. Nicol and E.L. Hutton, 'Some Clinical Aspects of General Paralysis', *Journal of Mental Science* **81** (October 1935), pp. 810, 814. Nicol worked at Hanwell (LCC) before 1927, where it seems the patient first received convalescence, after which they returned to institutional care at a different mental hospital (Springfield, Surrey).

⁹⁹ Hubert Bond, 'After-Care in Cases of Mental Disorder, and the Desirability of its More Extended Scope', *Journal of Mental Science* **60** (April 1913), pp. 280-1.

¹⁰⁰ WLHUM, MACA, Case Files, 4118 (Ernest S), 14 September 1914, 28772 (Annie W), 27 December 1892 and 31 December 1892, 4077 (Lillian T), 1 January 1915.

when a patient had reached convalescence should rest with medical superintendents. Craig attributed relapses to families who impatiently discharged their relatives against medical advice and before convalescence had commenced.¹⁰¹ Craig thereby suggested that with careful medical oversight and management, convalescence could reliably follow the same course. Significantly, however, Craig also envisaged convalescence as a category centred upon professional expertise and judgement.¹⁰² The Royal Medico-Psychological Association (RMPA) in 1926 similarly interpreted convalescence as a medical 'test' and 'ordeal', primarily defined by psychiatrists with sufficient skill to determine its onset and conclusion.¹⁰³

Nevertheless, as Maurice Craig's comments suggest, patients and their families seem to have maintained their own views on their need for convalescence, sometimes in direct contravention of medical advice. Registers record two instances where patients rejected convalescence after meeting with Craig and 'refused' to go to the charity's homes.¹⁰⁴ Other cases similarly refused help, including William S., who apparently claimed he 'desired to have nothing to do with the Associat[io]n'.¹⁰⁵ While superintendents exercised considerable control over when a patient could access organised convalescence, therefore, patients could – and did – decline further care. As such, patients actively interpreted the extent of their

¹⁰¹ Shepherd's analysis of Brookwood Asylum in Surrey supports this attribution, which has suggested the majority of relapsed cases came from those discharged at the request of families and friends. See Shepherd, 'Female Patient Experience', pp. 228-9.

¹⁰² Maurice Craig, *Psychological Medicine: A Manual of Mental Disorders for Practitioners and Students* (London: J. & A. Churchill, 1926, 4th edition), pp. 368-9.

¹⁰³ 'The Report of the Royal Commission on Lunacy and Mental Disorder', *Journal of Mental Science* **72** (October 1926), p. 605.

¹⁰⁴ WLHUM, MACA, Agenda Case Books, 11 June 1914 (Philip A. T), 31 January 1918 (Esther Lydia M)

¹⁰⁵ *Ibid.*, 13 January 1910 (Kate C), 14 March 1918 (Helena G), 27 December 1924 (Aby S), 27 May 1925 (Annetta F. G); WLHUM, MACA, Case Files, 4531 (William S, alias Walter P), 28 July 1910.

recoveries and their need for further treatment. When Ellen Margaret R visited the MACA's offices in March 1915, she initially declined cottage home treatment, because 'she did not think it was necessary... as she was quite well'.¹⁰⁶ Other patients and their families however, seem to have actively requested and embraced convalescence, and in some cases themselves met with rejection.¹⁰⁷ Before the MACA began to help early care patients in 1924, it routinely refused help to patients such as Lillian T who had not recently been received into an asylum or infirmary. While Lillian T's request for placement in a convalescent home indicates she considered herself almost recovered, the Association's rules precluded her from treatment.¹⁰⁸ By limiting its help to certain groups, the MACA helped define which groups could feasibly consider themselves mentally convalescent. The Association in 1911 claimed to make no distinction according to age, yet it withheld convalescence from three patients in 1923 on this basis.¹⁰⁹ Epileptic and mental defectives were routinely referred elsewhere for boarding-out after 1913, and those still considered insane also rejected.¹¹⁰

Superintendents and the MACA therefore helped frame patients' expectations of convalescence, whilst patients differed in how far they perceived themselves as convalescents at all. Consequently, named

¹⁰⁶ WLHUM, MACA, Case Files, 4417 (Ellen Margaret R) [oblit.] March 1915.

¹⁰⁷ Ibid., 4061 (Isabella E. F), 10 June 1914.

¹⁰⁸ Ibid., 4077 (Lillian T) 2 July 1914, 11 July 1914, 24 November 1914; WLHUM, MACA, Agenda Case Books, 14 March 1918 (Jeremiah C), 16 May 1918 (Frederick M), 31 March 1921 (F.H. B), 21 January 1925 (Duncan B)

¹⁰⁹ Henry Hawkins had originally envisaged that the Association would not serve the elderly, or patients under sixteen years of age. The age of the three rejected applicants is unclear from the Agenda Case Books alone. WLHUM, MACA, Agenda Case Books, 7 March 1923 (Marie F.), 29 March 1923 (Theresa I and Mary Ann I); Henry Hawkins, 'After Care', *Journal of Mental Science* **24** (October 1879), p. 365.

¹¹⁰ WLHUM, MACA, Agenda Case Books, 23 July 1914 (Charles A), 29 October 1914 (William H. P), 29 October 1914 (Fanny D), 31 January 1914 ('Mrs Edward's case'), 16 February 1921 (Doris P), 23 March 1922 (Joyce M), 27 September 1922 (George A. C), 23 March 1923 (Miss L and Joyce M), 28 December 1924 ('Dr Sweet's case').

convalescents, and those that sought convalescent status, made 'choices, adaptations [and]... adoptions' in how they sought to envision their recoveries, based on an interpretive interaction with providers and others.¹¹¹ Those such as Esther M and Annetta G who refused cottage home convalescence simultaneously repudiated its importance to their own ongoing improvement.¹¹² Equally, patients and families who outwardly accepted medical advice on recovery reflected on procedures in the light of their own lay experiences. John R's respectfulness towards his own asylum superintendents in his letter to the MACA was perhaps prudent given the likelihood that his appeal for release would be read by other psychiatric doctors involved in the charity. His observation that 'they move but very slowly in these places', however, also indicates the extent to which this patient maintained his own perspective on the suitable timescale for his observation and release.¹¹³ Marion King's vignette of her realisation that she was to be discharged indicates a similar surprise at the length of time this would take. Recalling how she had overheard the doctor on the phone that it would take three months, King later recalled 'I thought to myself, why that is nearly as long as I have been here'. The doctor's comment on the phone that 'yes, it generally takes that long!' similarly suggests that others with an interest in King's case outside the hospital shared her questioning attitude.¹¹⁴ It seems likely therefore that patients queried the necessity of extended medical supervision, against the opinion of those superintendents involved in

¹¹¹ Hacking, *The Social Construction of What?*, pp. 31-4.

¹¹² WLHUM, MACA, Agenda Case Books, 31 January 1918 (Esther Lydia M), 27 May 1925 (Annetta F. G)

¹¹³ WLHUM, MACA, Case File Correspondence, John R, p. 2.

¹¹⁴ King, *Recovery of Myself*, pp. 127-8.

the MACA's work, such as Maurice Craig and James Crichton-Browne, who idealised lengthy convalescences.¹¹⁵

Advertisements placed in the national press for nerve tonics indicate the extent to which convalescence may have provided some patients with a desirable and elective identity. Companies such as Sanotogen, Ovaltine and Allen and Hanbury's regularly advertised their products in the national press as restorative tonics for a wide range of ailments, including nervous disorders and convalescence. Such tonics were typically promoted for a wide range of preventive and restorative purposes, and therefore sold to a wider public than simply recuperating patients and sufferers from psychiatric conditions. Nevertheless, advertisers do appear to have identified a domestic market for convalescence. Some companies such as Benger's Foods and Sanatogen, for example, addressed their products to those 'in convalescence' and therefore directly linked their tonics with recuperation.¹¹⁶ The fact manufacturers targeted such products at convalescence and nervousness suggests they perceived both as conditions that potential buyers might privately identify with outside institutional care.¹¹⁷ Illustrations for products such as Sanatogen and Bovo-Lactin depicted domestic scenes, which together with medical endorsements, reinforced the idea that these products offered consumers a self-administered adjunct or alternative to

¹¹⁵ Both were appointed members of the MACA: Craig as treasurer (1921-29) and briefly chairman (1930-31), while Crichton-Browne was vice-president in the 1920 and 1930s.

¹¹⁶ 'In Convalescence: Sanatogen', *The Times* (Monday 20 October 1930), p. 21, **45648**, col. F; 'In Convalescence, Benger's Food', *The Times* (Monday 15 November 1937), p. 12, **47842**, col. A.

¹¹⁷ Some like Guinness and Bovo-Lactin referred specifically to nervousness and neurasthenia, as well as convalescence. See 'Doctors Recommend Guinness as a Tonic of Permanent Value', *The Times* (Friday 8 November 1929), p. 5, **45355**, col. D; 'The Price of Bovo-Lactin is Reduced: Bovo-Lactin Essence', *The Times* (Monday 3 November 1924), p. 9, **43799**, col. E.

supervised medical treatment.¹¹⁸ Their general availability in interwar chemist shops allowed convalescents – potentially including those recovering from mental and nervous disorders – to treat themselves as convalescents in their own homes. Adverts sometimes addressed patients directly, such as Sanatogen, which claimed it could help ‘strengthen the nerves’ among convalescents from ‘debilitating diseases’.¹¹⁹ Mathew Thomson has suggested such somatic explanations of nerves may have appealed to the public; at the least it does suggest advertisers anticipated a market for tonics amongst nervous patients.¹²⁰ Several alienists and psychiatrists prescribed comparable easily digested tonics for mental convalescents in contemporary psychiatric textbooks.¹²¹ This followed a long tradition of their use within private institutions such as Ticehurst, though it is less clear how frequently such treatments were used on convalescents in public mental hospitals.¹²²

¹¹⁸ Adverts for tonics regularly cited or alluded to medical endorsements. E.g., ‘The Rational Nightcap for Refreshing Sleep: “Allenburys” Diet’, *The Times* (Wednesday 21 February 1923), p. 8, **43271**, col. A; ‘Enter Glorious Spirit of Health: Sanatogen’, *The Times* (Tuesday 16 October 1923), p. 5, **43473**, col. E; ‘Doctors Recommend Guinness as a Tonic of Permanent Value’, *The Times* (Friday 8 November 1929), p. 5, **45355**, col.D; ‘Benger’s Food: Invaluable’, *The Times* (Friday 25 October 1935), p. 9, **47204**, col E.

¹¹⁹ ‘In Convalescence: Sanatogen’, *The Times* (Monday 20 October 1930), p. 21, **45648**, col. F.

¹²⁰ Mathew Thomson, *Psychological Subjects: Identity, Culture and Health in Britain* (Oxford and New York: Oxford University Press, 2006), p. 38.

¹²¹ George H. Savage and Edwin Goodall, *Insanity and Allied Neuroses: A Practical and Clinical Manual* (London and Paris: Cassell, 1907, 4th edition), pp. 126, 207; T.S. Clouston, *Unsoundness of Mind* (London: Methuen, 1911), pp. 146, 290; R.H. Cole, *Mental Diseases: A Text-Book of Psychiatry for Medical Students and Practitioners* (London: University of London Press, 1913, 1st edition), p. 123; Hubert J. Norman, *Mental Disorders: A Handbook for Students and Practitioners* (Edinburgh: E&S Livingstone, 1928), pp. 151, 160; Robert Hunter Steen, *The Modern Mental Hospital* (London: Methuen, 1927), p. 59.

¹²² Most of the textbooks cited were published by superintendents at private and registered mental institutions, or general hospitals, rather than public mental hospitals, respectively: Camberwell House (Norman), City of London Mental Hospital (Steen), St Mary’s Hospital (Cole), and private practice (Savage). The exceptions were Clouston, who had retired from institutional practice in 1908, having previously worked at Morningside Asylum, and Goodall, who acted as Medical Superintendent at Cardiff City Mental Hospital. On the use of tonics at Ticehurst, see Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London and New York: Routledge, 1992), p. 140.

An isolated reference in Annie H's case-history suggests how families and carers may have utilised tonics to sustain convalescence and prevent relapse. Annie H was sent from Hill End Asylum in September 1916 for convalescence with the MACA, before being placed as a domestic servant after a month; she was initially reported sufficiently 'well' and the Association closed and initialled her file. By June 1917, however, her new employer expressed concerns that Annie's condition had again deteriorated, and reported that Annie had gone to a panel doctor and was 'taking a tonic'. A few weeks later, Annie herself wrote that she had stayed with her sister in Portsmouth for a fortnight's 'holiday' with her sister and felt 'quite well now'. In this case, it therefore appears that Annie's employer regarded the tonic as a preventive measure against relapse that might guard against further institutional treatment, although her employer also raised the possibility that Annie might benefit from attendance by the MACA's doctors. The subsequent record of Annie's letter linked her improvement with her break away from home, however, which perhaps hints at the different attributions different patients and carers may have offered for their successful convalescence.¹²³ Patient letters written during and after treatment in the MACA's cottage homes suggest other convalescents perceived a physiological basis behind their treatment. Extracts in the MACA's reports regularly focused on the rest and food they had received, and in one case a patient referred to their 'invalid diet' within the home.¹²⁴ Another emphasised his doctor's pleasure at the weight he had gained during convalescence.¹²⁵

¹²³ WLHUM, MACA, Case Files, 5001 (Annie H), 13 September 1916, 13 October 1916, 10 June 1917, 20 August 1917.

¹²⁴ WLHUM, MACA, Annual Report, 1936, p. 11 (case 27573).

¹²⁵ *Ibid.*, pp. 10-11 (case 31669).

Both cases identified their convalescence with physical health and diet, in ways that paralleled the claims advertisers often made for tonics as digestive and nourishment.

The majority of extracts from patient letters reproduced in the MACA's reports framed their stay in cottage homes as a holiday, and interpreted the food they received pleurably for its quality and quantity, rather than for its health benefits.¹²⁶ In these fragmentary representations, convalescence appears more an enjoyable and restorative break from community existence than a psychiatric process. This corresponds with a comparable preference for environmental and neurological aetiology amongst patients that historians of psychiatry have identified in other nineteenth and early twentieth-century contexts.¹²⁷ Advertisers and the MACA each claimed their aids to convalescence helped remedy socially-caused threats to recovery. Publicity for Sanatogen in 1938, for example, alleged it 'replace[d]... the nervous energy that work and worry drain away'. This paralleled the MACA's claim that its homes helped shelter patients from a 'world of work and worry' during their convalescence.¹²⁸ Abbreviated summaries of patient case-histories reproduced in the MACA's reports often blamed overwork, pressured

¹²⁶ E.g., WLHUM, MACA, Annual Report, 1937, pp. 10-11 (cases 32100, 32413 and 32604).

¹²⁷ Several historians of psychiatry and mental disability have perceived that patients and their families rarely wanted to attribute their illness to heredity or biological origins. See Edward Shorter, 'Private Clinics in Central Europe, 1850-1933', *Social History of Medicine* 3 (September 1990), pp. 176, 180; Gittins, *Madness in its Place*, pp. 128-32; Mathew Thomson, *Problem of Mental Deficiency* (Oxford: Oxford University Press, 1998), p. 262; Akihito Suzuki, 'Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London', in Roberta Bivins and John V. Pickstone (eds), *Medicine, Madness and Social History: Essays in Honour of Roy Porter* (Basingstoke: Palgrave Macmillan, 2007), pp. 121-2.

¹²⁸ 'Don't Let Life Crush You!: Renew Your Vital Forces with Daily Sanatogen', *The Times* (11 January 1938), p. 14, **47889**, col. F. Descriptions of the MACA in the 1930s repeatedly referred to its work in protecting patients against 'a world of work and worry'. See LMA, LCC, Mental Hospitals Committee, General Purposes Sub-Committee, 1920-1939, LCC/MIN/696-701, 17 February 1931, p. 446, Second Report of Mental Treatment Committee; WLHUM, MACA, Press Cuttings from Albums, 'A Beneficent Ministry', *Christian* (6 December 1934); WLHUM, MACA, Publicity Sheets, SA/MAC/H.2/1, [untitled publicity sheet] [1938].

domestic conditions and other circumstantial factors that underlay the patient's need for help. Those that made no reference to the cause of illness usually emphasised the social capabilities convalescents had acquired as a result of their treatment. Unlike the letters reproduced in the MACA's reports, that sent by 'A Sufferer' to the *Daily Telegraph* in March 1927 provides a short but complete account by a former patient on the treatment they received through the MACA. Like those letters reproduced in the MACA's reports, this letter accentuated the protection the charity's care had provided them from the 'frightful hardships' they found upon their discharge into 'a harsh and apathetic world'.¹²⁹ Such explanations identified social obstacles to readjustment, and interpreted the MACA's intervention and its convalescence as a salve for essentially social stresses.¹³⁰

4. Escape and Belonging: Patient Agency and Recovery

Registers suggest that most patients accepted the convalescence the MACA offered them. Repayments to the Association patients and their families later made for their treatment, and the contact some patients sustained with the charity and cottage home matrons, further suggests many valued and felt they had benefited from their stay.¹³¹ Nevertheless, a few patients declined further help. Among those sent to cottage homes, some later escaped, proved 'difficult', or rejected the advice of their carers. As Greta Jones has

¹²⁹ WLHUM, MACA, Press Cuttings from Albums, 1897-1965, SA/MAC/H.1/2-5, "A. Sufferer", 'Mental After-Care, *Daily Telegraph* [March 1927].

¹³⁰ Diana Gittins and Akihito Suzuki have suggested many patients may have interpreted their institutionalisation in asylums in a similar way, as a phase in their life forced upon them by stressful domestic and occupational circumstances. See Gittins, *Madness in its Place*, pp. 128-9; Suzuki, 'Lunacy and Labouring Men', p. 121.

¹³¹ WLHUM, MACA, *Annual Report*, 1926, p. 4; WLHUM, MACA, Registers.

identified among tuberculosis patients offered sanatorium treatment in interwar Ireland, mental convalescents sometimes resisted institutionalisation. Sanatoria offered a comparably holistic therapeutic regime to cottage homes for convalescents, centred on fresh air, rest, and nutrition. The intangibility and brevity of convalescence perhaps encouraged some patients to regard it as unnecessary, and felt themselves sufficiently equipped to manage their own recoveries. Convalescents may have attempted to manage their illnesses in their own homes, as Jones has suggested the tuberculous were sometimes encouraged to do on similar holistic therapeutic principles.¹³² Several private patients and their kinfolk requested addresses for private nursing homes from the Association, and newspaper adverts and directories listed hundreds of homes for those who wished (and could afford) to manage their own healthcare.¹³³ Another private patient, registers recorded, had 'gone to her own home' after she had refused to take the convalescence the Association had offered.¹³⁴ Rate assisted patients similarly rejected convalescence, and may have either attempted to convalesce themselves or simply returned to work.¹³⁵ For those such as Ellen Margaret R who identified themselves as recovered, and only

¹³² Jones instances one sanatoria where two-thirds of tuberculosis cases remained longer than three months, which represented the normal maximum stay for patients in the MACA's cottage homes. Greta Jones, *"Captain of all these Men of Death": The History of Tuberculosis in Nineteenth and Twentieth Century Ireland* (Amsterdam and New York: Rodopi, 2001), pp. 160, 163.

¹³³ *Nursing Homes 1931: A Directory of Nursing and Convalescent Homes in England and Wales* (South Lancing: J. Eaton Hosking, c.1931, 2nd edition); *Nursing Homes 1934: A Directory of Nursing and Convalescent Homes, Mental Homes etc...* (London: Benn Brothers, 1934, 4th edition); MacKenzie, *Psychiatry for the Rich*, p. 208.

¹³⁴ WLHUM, MACA, Agenda Case Books, 5790 (Dr Haynes' case), 16 May 1918.

¹³⁵ *Ibid.*, 4039 (Philip A. T), 11 June 1914; 5378 (Esther L. M), 31 January 1918.

reluctantly accepted cottage home treatment, they may have felt that they already belonged in the wider community and workplace.¹³⁶

Convalescent homes were not intended for all discharged patients, and like other home-like institutions for the mentally disordered, such as the institutions for mental defectives Pamela Dale has studied, provided particularly for problematic cases.¹³⁷ Many patients returned directly from mental hospitals to their own homes, where the MACA visited or provided money *in situ*.¹³⁸ In other instances, the charity first explored whether other carers might take a patient before they decided to provide convalescence, as summarily recorded in a case in 1923: 'friends visited: not suitable, convalescence agreed upon'.¹³⁹ Annual reports indicate the charity took some cases for convalescence after spouses refused to take them back, and when a patient's home appeared unsuitable.¹⁴⁰ Environmental criteria clearly determined convalescence in some cases. One girl's home was 'found to be... very unsatisfactory... so we sent her to a convalescent home' (23525), while another man was reported 'now in our home on trial after seeing his own home' (10478).¹⁴¹ Assessment on whether a patient required convalescence therefore depended upon their prospects for a stable home-life, beyond purely psychiatric considerations for their prognosis. Before the 1930s, superintendents, relieving officers and other interested parties

¹³⁶ WLHUM, MACA, Case Files, 4417 (Ellen Margaret R), [oblit] March 1915.

¹³⁷ Pamela Dale, 'Implementing the 1913 Mental Deficiency Act: Competing Priorities and Resource Constraint Evident in the South West of England before 1948', *Social History of Medicine* 16 (December 2003), p. 406.

¹³⁸ E.g., WLHUM, MACA, Case Files, SA/MAC/G.3/40, [No Ref], (Bridget Margaret C).

¹³⁹ WLHUM, MACA, Agenda Case Books, 8778 (Elizabeth R), 7 March 1923.

¹⁴⁰ WLHUM, MACA, Annual Report, 1932, pp. 14-15, (case 22426); 1933, pp. 13-14 (cases 24542 and 33386); 1936, p. 12, (cases 31506, 31512 and 31701); 1937, p. 12 (case 33386).

¹⁴¹ *Ibid.*, 1933, p. 13, case 23525; WLHUM, MACA, Registers, 10478 (Richard W), 21 January.

supplied details on patients' medical and social background, from which the MACA's case-workers explored the social circumstances of each case in more detail.¹⁴² It is likely that the delegation of referrals to psychiatric social workers in several mental hospitals in the 1930s encouraged a concentration of convalescence on those without suitable homes, before the MACA's own workers became involved. Where possible, the London County Council's trained social workers claimed they sought to mediate relationships between patients and their families before discharge, and afterwards in the community.¹⁴³ Ewell's worker, Dorothy Lilley, claimed she primarily referred patients to the MACA for convalescence where relatives or friends were 'unable to accept responsibility'.¹⁴⁴

While some families actively petitioned for the early release of their institutionalised relatives from asylums, others withheld support or abandoned them upon their discharge. This left convalescence as a second choice in those cases where the MACA had initially attempted to locate friends and relatives to take responsibility. An entry in the case-registers from 1918 recorded that Donald F. C had gone to the MACA's home after his 'father refused help', and others also arrived there after relatives known to the authorities on admission proved unwilling to assist.¹⁴⁵ The charity boarded-out and convalesced men and women whose spouses had deserted

¹⁴² E.g., WLHUM, MACA, Case Files, 4080 (Ernest Henry C.), 21 July 1914; 4110 (Camilla N.), 14 and 15 August 1914; 4052 (Elizabeth S.), 8 and 10 September 1914; 4061 (Isabella E. F.), 19 August 1921.

¹⁴³ LMA, LCC, Mental Hospitals Committee Presented Papers, 1920-39, LCC/MIN/607-660, D.R. Montford (Psychiatric Social Worker, Banstead), 'The Uses of a Trained Social Worker Stationed at a Mental Hospital', n.d., pp. 1-2; D. Lilley, 'Report of Social Worker [at Ewell] for the Period 1.10.31 to 31.5.33', p. 3.

¹⁴⁴ Ibid., D. Lilley, 'Report of Social Worker [at Ewell] for the Period 1.10.31 to 31.5.33', 18 July 1933, p. 4.

¹⁴⁵ WLHUM, MACA, *Annual Reports*, 1933, pp. 13-4, (cases 23694 and 24542); 1936, p. 12 (case 31506).

them.¹⁴⁶ Throughout the period, the law provided no recourse for married partners who wished to divorce convalescent spouses, though the Matrimonial Causes Act, 1937, provided for divorce on the basis of incurable insanity.¹⁴⁷ Some evidently walked away from their newly convalescent spouses, such as the husband of patient 27443, who the MACA reported had 'gone to live with another woman'.¹⁴⁸ From the late 1920s, the LCC's psychiatric social workers purported to help patients and their families 'adjust' to their circumstances, where they remained amenable, through more attention to the domestic causes of disharmony. Their reports presented convalescence as just one stratagem within a broader ongoing attempt to manage interpersonal relations between family members. Trained social workers suggested that while convalescence might occasionally provide the necessary distance between patients and families maladjusted to one another, the more important work centred on external relationships in the community.¹⁴⁹ The MACA tended to highlight the break its cottage homes temporarily provided those without other options conducive to recovery. In contrast, social workers represented mental health as a concept relative to – and reliant upon – a network of social relationships.

Consequently, providers and assessors particularly privileged convalescence for patients without suitable friends or relations able to care

¹⁴⁶ WLHUM, MACA, *Annual Reports*, 1935 (p. 11, case 28432), 1937 (pp. 12-13, cases 33386 and 27443); WLHUM, MACA, Registers, 5713 (Kate P), 4 April 1918; 5731 (John J.H. E), 15 January 1920; WLHUM, MACA, Press Cuttings from Albums, 'Plight of the Deserted Wife: A Doctor on Cases of Mental Recovery', *The Universe* (13 July 1928).

¹⁴⁷ Incurable insanity was calculated under the Act as a period of five years from certification, after which time petitioners could file for divorce. The Act came into force in 1938. Robert Armstrong-Jones (Letters), 'The New Divorce Law', *British Medical Journal* 28 (May 1938), p. 1177; Lawrence Stone, *The Road to Divorce: England, 1530-1987* (Oxford and New York: Oxford University Press, 1990), pp. 399-400.

¹⁴⁸ WLHUM, MACA, *Annual Report*, 1937, p. 13 (case 27443).

¹⁴⁹ LMA, LCC, Presented Papers, Montfort, 'Uses of a Trained Social Worker', pp. 1-2; Lilley, 'Report of Social Worker for the Period 1 October 1931 to 31 May 1933', pp. 8-9.

for them. Nevertheless, many convalescents returned afterwards to their spouses, parents and friends.¹⁵⁰ For these patients, convalescence provided a hiatus between institutionalisation and resumption of community-based relationships. One patient considered their convalescent placement a 'home from home', and therefore conveyed the sense that their stay had mimicked the type of home they already possessed in the community. The patient noted how pleased their children appeared to have them 'home', and underlined their domestic role within this family, in the comment that they were 'now having a good clean up'.¹⁵¹ Distance and time away from home may have accentuated patients' sense that convalescence had provided an interlude in otherwise continuous experiences of home in the community. Three cases discharged in the early 1920s from London mental hospitals, and then convalesced, were subsequently helped to return to Ireland, which at least episodically linked their convalescence with their relocation back to their former country.¹⁵² The return of one of these patients for further convalescence in 1922, however, betrays the complexity of relapsed patients' careers, where convalescence resulted in only one of multiple returns 'home' or moves elsewhere.¹⁵³ The question 'where was "Home"?' raised in Catharine Coleborne's work highlights the diverse domestic conditions patients might have been expected to return to, if indeed they had

¹⁵⁰ E.g., WLHUM, MACA, *Annual Reports*, 1933, p. 14 (case 18388), 1936, pp. 10-11 (case 31669), 1937 (pp. 11-12, case 32204); WLHUM, MACA, *Agenda Case Books*, 4082 (Hannah H), 3 September 1914; 4167 (Mrs Rose M. L), 30 December 1914; 5530 (Mrs Annie G), 10 January 1918; 6220 (Dorothy M.G. W), 26 February 1920; 8305 (Maud B), 7 September 1922; 8416 (Minnie C), 28 September 1922.

¹⁵¹ WLHUM, MACA, *Annual Report*, 1936 (pp. 10-11, case 31669).

¹⁵² WLHUM, MACA, *Agenda Case Books*, 7061 (Bella G), 2 September 1920; 7644 (Jenine C. [sic]), 27 October 1921, 30 November 1922; 10202 (John B), 23 October 1924.

¹⁵³ *Ibid.*, 7644 (Jenine C [sic]), 27 October 1921, 30 November 1922.

anywhere to return to at all.¹⁵⁴ For those placed in domestic service, convalescence resulted in continued separation from filial relations, and a departure to somewhere new. The 'bridge' convalescence afforded, and the sense of home it provided, is therefore likely to have varied according to patients' pre-existent connections and identification with a fixed home in the wider community.

The MACA's description of its homes as a 'sympathetic and understanding family' suggests the charity intended its homes should provide residents with a surrogate and idealised familial environment.¹⁵⁵ Some within the Association even hinted that cottage homes could provide a better home environment than patients' own families. Dr Reginald Worth claimed the only distinction between the 'family' available to patients in cottage homes, and blood-relations, was that 'the head of the "family" [in our homes] is a skilled individual and as such possesses the tact, understanding and sympathy so necessary' during convalescence.¹⁵⁶ Such claims for the superior familial environment achieved in cottage homes mirrored contemporary psychiatric assertions, which emphasised the need for professional expertise and knowledge during recovery. For psychiatrists such as Maurice Craig, institutions provided a therapeutic barrier between families and the convalescent.¹⁵⁷ Alongside psychiatric claims for the homeliness re-creatable

¹⁵⁴ Coleborne, 'Families, Insanity, and the Psychiatric Institution', pp. 69-70.

¹⁵⁵ WLHUM, MACA, Annual Report, 1925, p. 5; WLHUM, MACA, Press Cuttings from Albums, 'After-Care Work in Mental Treatment: Review of the Mental After-Care Association's Activities', *Public Assistance Journal*, c. June 1930.

¹⁵⁶ WLHUM, MACA, Press Cuttings from Albums, Reginald Worth (Chairman, MACA), 'After-Care of Mental Patients', paper given to Central Association for Mental Welfare Public Health Congress, 1934.

¹⁵⁷ Craig, *Psychological Medicine*, pp. 442-4. On J.R. Lord's psychiatric claims to expert knowledge during institutional treatment and recovery, see also Stephen Soanes, 'Reforming Asylums, Reforming Public Attitudes: J.R. Lord and Montagu Lomax's

and perfectible within institutions, ran a countervailing concern that patients might become overly comfortable in their temporary half-way houses. Within mental hospitals, the Board of Control partially justified convalescent villas as a means to disrupt the personal attachments and routines patients had formed in admission hospitals. The Board noted patients 'not infrequently... plead[ed] not to be moved pending their ultimate discharge', and raised the function convalescent villas could serve in breaking this attachment; an attachment William Seabrook and Marion King evidently felt towards patients in previous wards. To some extent, therefore, the Board's programme for convalescent villa construction served to wean hospital residents from permanent attachment to their institutions.¹⁵⁸ In contrast, the MACA actively encouraged ex-convalescents to feel an attachment to its staff, after they left, and boasted in 1926 that patients 'frequently return to visit the homes to which they were formerly attached'.¹⁵⁹

It appears from patient letters that some at least may have regarded their cottage home co-residents as a family. 'The matron is, as the word means, a mother' one patient (case 21627) wrote after their convalescence at Herne Bay, while another (case 27573) referred to their matron as 'motherly'.¹⁶⁰ Use of such terms suggests convalescents themselves sometimes identified a familial dimension to their care, which placed them in

Representations of Mental Hospitals and the Public, 1921-31', *Family and Community History* 12:2 (November 2009), pp. 125-6.

¹⁵⁸ This mirrored John Conolly's comment almost a century earlier (1830) on the difficulty in persuading patients to leave: 'how few are happy to escape!'. *The Eleventh Annual Report of the Board of Control for the Year 1924* (London: H.M. Stationary Office, 1925), p. 15; Seabrook, *Asylum*, p. 215; King, *Recovery of Myself*, p. 83; John Conolly, *An Inquiry Concerning the Indications of Insanity with Suggestions for the Better Protection and Care of the Insane* (London: John Taylor, 1830), p. 21.

¹⁵⁹ WLHUM, MACA, *Annual Report*, 1926, p. 4.

¹⁶⁰ *Ibid.*, p. 12 (case 21627); 1936, p. 11 (case 27573).

the role of children. This parallels a similar sense of dependency to William Seabrook's description of his fellow convalescent villa residents inside mental hospitals as 'playmates', which alluded to the quasi-parental role his keepers maintained over their care.¹⁶¹ More frequently, letters republished in the MACA's reports acknowledged the 'kindness' matrons had shown, which implied a similarly respectful but less emotionally intimate relationship between convalescents and their carers.¹⁶² The frequent references made to convalescence as a holiday in published patient letters cast matrons in the light of boarding house owners and consequently as welcome but temporary facilitators, rather than close and lasting friends or 'family'. In turn, cottage home matrons wrote warmly of some patients. Mr Wood apparently gave a 'very good account' of Ernest S, after his referral in 1914. A fortnight later, Mr Wood wrote that he considered Ernest the 'best mannered and most sane man they had had', and took it upon himself to help Ernest find employment.¹⁶³ Wood's particular request that he might help the patient find work suggests that he felt a bond and responsibility towards this particular individual. Meanwhile, Ernest's subsequent voluntary return to the home for further convalescence, after his first job proved too arduous, suggests he too may have felt welcome in the Woods' household, and felt some sense of belonging there.

Pre-existent relations with those in the wider community are also likely to have influenced how convalescents felt about their place in society.

Payments in several cases came from 'friends' of convalescents, sons,

¹⁶¹ Seabrook, *Asylum*, p. 215.

¹⁶² WLHUM, MACA, *Annual Reports*, 1935, p. 10 (case 28613); 1936, pp. 10-11 (cases 31318 and 31669).

¹⁶³ WLHUM, MACA, Case Files, 4118 (Ernest S), 4 and 18 December 1914.

husbands, and sometimes patients themselves. Of the 311 patients accepted for convalescence in 1924, at least thirty-two (10.3 per cent) received support through friends and family members.¹⁶⁴ Those already known to patients therefore in some cases endorsed their stay in a home through their financial support. Families petitioned for convalescence for their relatives, and tacitly cooperated in the process through agreements to take patients on their return.¹⁶⁵ An indeterminate number of spouses and siblings also wrote to the Association in appreciation of the convalescence it had provided their relations. The gratitude expressed in other cases, and visits friends made to the Association, on behalf of recovering patients further suggest that some remained in 'ongoing dialogue' with those responsible for care into the twentieth century.¹⁶⁶ One husband (of case 18388) wrote that he felt 'exceedingly grateful to you and others concerned for making it possible for poor people to recuperate in this manner'. More personally, the daughter of another woman (case 22889) commented on the benefits sympathy and rest had brought her mother during her time away. Patients' letters also conveyed the thanks felt by others in their family.¹⁶⁷ Such diverse familial involvement indicates that relatives not only committed and discharged their members to asylums on the basis of strategic need, as historians have argued, but moreover sought out or gave consent to intermediate care arrangements

¹⁶⁴ WLHUM, MACA, Registers, 1924.

¹⁶⁵ See especially case 4061 (Isabella E. F), whose sister in 1921 'agreed to take patient to live with her at Worthing after a month on trial with us [i.e., MACA]'. WLHUM, MACA, Registers, 4082 (Hannah H), 23 July and 6 August 1914; 6039 (Blanche N), 21 November 1918, and 1 June and 27 October 1921; 5725 (Mrs Mary A. E), 25 April 1918; WLHUM, MACA, Case Files, 4061 (Isabella E. F), 10 and 15 June 1914, and 16 September 1921; 4064 (Rebecca H), 29 June, 1 and 30 July 1914.

¹⁶⁶ Smith, 'Your Very Thankful Inmate', p. 237.

¹⁶⁷ WLHUM, MACA, Annual Report, 1933, p. 12 (case 18388); 1932, p. 15 (case 22889); 1933.

intended to confirm recovery.¹⁶⁸ Friends and advocates also sometimes helped, like Miss Gray, who though evidently not a relation, visited and endorsed the home to which the MACA sent Edith Vere E, and underwrote her costs.¹⁶⁹

In contrast with those whose families actively supported their convalescence, the MACA's reports suggested others received treatment precisely because they lacked family support, or other options for community-based care. As Catharine Coleborne's work on Australasian asylum visiting has suggested, some patients apparently remained distant from their families through choice or neglect, whereas others benefited from care that relatives negotiated on their behalf.¹⁷⁰ It is likely the MACA selectively reproduced stories of loss and dispossession in its annual reports, which would have had an emotional appeal to its readers. Case records indicate that many families actively supported their relatives during convalescence, which in contrast, are relatively underrepresented in the charity's reports. Nevertheless, the referrals MACA workers occasionally made to relevant agencies in cases of domestic abuse, and the frequency with which the MACA could cite cases of friendlessness, suggest that

¹⁶⁸ On families' strategic use of institutional care for the mentally disordered, see John Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-70', in W.F. Bynam, Roy Porter, and Michael Shepherd (eds), *Madness: Essays in the History of Psychiatry, Volume II: Institutions and Society* (London: Tavistock, 1985), pp. 132-46; David Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine* **10** (March 1997); Thomson, *Problem of Mental Deficiency*, pp. 261-4; Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient and the Family in England, 1820-1860* (Los Angeles, CA, and London: University of California Press, 2006), especially pp. 180-1.

¹⁶⁹ WLHUM, MACA, Case Files, 4897 (Mrs Edith Vere E), especially 7 June, 1 August, and 21 October 1916

¹⁷⁰ Coleborne, 'Challenging Institutional Hegemony', pp. 289-90, 301.

convalescence may have offered a refuge for some.¹⁷¹ In one case the Association provided a middle-aged woman with convalescence after they had ‘found her friends had all turned her away’, even though her doctor considered she had ‘made a good recovery’.¹⁷² This suggests convalescence in some cases served a preponderantly social function. In others, the MACA emphasised the medical benefits that its help provided to those with nowhere else to go. Reginald Worth reported how the charity had convalesced a man who ‘had no friends in England and no home’, as a preferable option to placement in a workhouse, which Worth suggested would have precipitated his relapse.¹⁷³ These exemplify cases for which convalescence may have offered a temporary home for those without other options, even though it remains unclear from available sources how far these and other such patients welcomed the MACA’s intervention.

Wartime offered particular opportunities for men to leave unsatisfactory prospects for work and belonging in the wider community. Peter Barham has suggested that enlistment offered those with unhappy histories a means to transcend ‘doubt and uncertainty’. At the same time, Barham has contended that while the MACA may not have intentionally promoted enlistment, it ‘left patients to take their chances as best they could’, despite an awareness of the risks warfare presented to newly convalescent

¹⁷¹ Annie S (4076), visited in 1914 was referred to the Society for the Protection of Women (1857, and became national organisation in 1878). Workers referred another case handled in 1924 (8538) to the Royal Society for the Prevention of Cruelty to Children (1889). WLHUM, MACA, Registers, 23 July 1914, case 4076 (Annie S); 28 December 1923, case 8538 (anon.).

¹⁷² WLHUM, MACA, *Annual Report*, 1938, p. 20 (case 15351).

¹⁷³ WLHUM, MACA, Press Cuttings from Albums, Reginald Worth, ‘After-Care of Mental Patients’, paper given to CAMW Public Health Congress, 1934, example 1.

men.¹⁷⁴ Certainly, as Barham has indicated, the charity did little to prevent men from joining-up in the early years of the war.¹⁷⁵ However, Ernest S's case-file suggests that the MACA may have sought other options for patients where possible, even where convalescents themselves declared their intention to fight. Thus, while Ernest wrote to the MACA to say that 'he should like to join the army if they would accept him', when his cottage home carer identified alternative employment, the MACA wrote back gratefully that they thought it 'was better than enlisting'.¹⁷⁶ It does appear, as Barham has argued, that the MACA did little to prevent men from joining up in the early years of the war. Nevertheless, Ernest S's case also suggests they may have preferred convalescents to enter civilian employment where other prospects were available. This pragmatism was also reflected by one patient, Ernest Henry C, who had told the cottage home proprietor Mr Woolgar that he 'thought of joining the army if nothing else turned up'. With the independent encouragement of those outside the MACA, with 'no work around Worthing', and with a limit set on his convalescence Ernest Henry did eventually enlist, though others in the same period found civilian work.¹⁷⁷

A desire for change, either for environments removed from former institutional lives or for new work, is also evident in the choices some convalescents made over employment in peacetime. The MACA helped

¹⁷⁴ Peter Barham, *Forgotten Lunatics of the Great War* (New Haven: Yale University Press, 2004), p. 81.

¹⁷⁵ The charity did later report on the case (Albert Francis N) Barham cites as his central example of the MACA's *laissez-faire* approach to male placement during wartime. In 1920, the charity's registers reported that Albert Francis was 'now doing well in his work', after he had returned to civilian life. *Ibid.*, pp. 25-7; WLHUM, MACA, Registers, 4784 (Albert Francis N), 15 April 1920.

¹⁷⁶ WLHUM, MACA, Case Files, 4118 (Ernest S), 19 December 1914 and 28 January 1915.

¹⁷⁷ *Ibid.*, 4080 (Ernest Henry C), 19, 23 and 31 October and 26 November 1914; 4132 (George F), 29 October and 26 November 1914; 4136 (Isaac H. S), 29 October and 26 November 1914.

place patients such as case 12503 after their convalescence who were 'anxious to get to sea', and in other cases helped patients who had not been in employment for many years.¹⁷⁸ Before convalescence and retraining as a skilled clerk, the MACA observed that a patient approached them 'anxious to make a new start in a fresh neighbourhood'¹⁷⁹ As such, it seems some patients viewed convalescence less as a prelude to restitution to their former social positions, than a means to establish new social roles. It also appears that the charity itself sometimes pressured convalescents to change occupations, and to move to areas more conducive to permanent health. In one case in 1919, the MACA sought to 'persuade' a man from London to 'take a post in the country', while in another the charity expressed its 'hope' that a girl who had suffered serious illness would 'now start again and forget her sad home life'.¹⁸⁰ This suggests that the temporarily healthful 'change' convalescence provided may have also provided patients – and the MACA – with the opportunity to effect more permanent occupational changes. To some extent, therefore, the MACA's convalescence may have constituted part of an effort to adapt maladjusted patients to wider social conditions. The development of a pilot scheme with the LCC in 1939 to identify what Ethel Vickers termed '*really* suitable employment' for discharged patients partly built upon the charity's existing concern to promote positive lifestyle changes, whilst it also engaged with psychiatric social work techniques.¹⁸¹

¹⁷⁸ WLHUM, MACA, *Annual Report*, 1926, p.12, case 12503; Paul Winterton, *Mending Minds: The Truth about Our Mental Hospitals* (London: Peter Davies, 1938), p. 165.

¹⁷⁹ WLHUM, MACA, *Annual Report*, 1936, p. 12, case 31506.

¹⁸⁰ *Ibid.*, 1933, p. 14, case 24530; WLHUM, MACA, Registers, 16 October 1919 and 10 June 1920, 5138 (Charles C).

¹⁸¹ Working practices reflected an increasing confluence between the MACA and psychiatric social work. The MACA itself briefly offered its staff to mental hospitals as social workers after 1933, though Vicky Long has noted that this proved relatively short-lived. In turn, the

Not all patients, however, wanted to break with their pasts, and instead showed attachment to past contacts and contexts. The MACA supplied private patients with information on the availability of homes in certain areas, which suggests patients may have maintained their own criteria on where they chose to take their convalescence. A concentration of the MACA's homes in the south-east of England meant that working-class patients from other parts of the country had to travel further from their homes and families than wealthier patients, who Charlotte MacKenzie has noted had the additional option of purchasing care, which was potentially more accessible.¹⁸² The MACA in 1904 had intended for its local branches to find convenient cottage homes in their own districts.¹⁸³ Registers indicate that in the 1910s and early 1920s, the majority of patients convalesced through the charity came from the south-east of England. Despite this, it appears counties like Wiltshire, and boroughs like Derbyshire and Leicester continued to send patients considerable distances for convalescence.¹⁸⁴ Registers hint

MACA worked with the psychiatric social worker Kathleen Laurie in its project to find employment for LCC patients. Modern Records Centre, Association of Psychiatric Social Workers, MSS.378.APSW/P/16/14/2, E.D. Vickers, 'Foreword', in Kathleen F. Laurie, *Employable or Unemployable?: Report on Pioneer Experimental Work Covering Period Feb 6 1939–Aug 1 1940*, p. 1; WLHUM, MACA, Annual Reports, 1933, p. 5; WLHUM, MACA, Council Minutes, 4 November 1938; Vicky Long, 'Changing Public Representations of Mental Illness in Britain, 1870-1970' (unpublished PhD thesis, University of Warwick, 2004), pp. 182, 207.

¹⁸² The Yorkshire branch of the MACA appears from the charity's central office records to have been one of the few to consider establishing a separate home (c.1931-2) outside the south and south-east. WLHUM, MACA, Registers, 18 September 1919, case 6550 (Miss S); 24 May 1922, case 8114 (Mrs G); MacKenzie, *Psychiatry for the Rich*, pp. 214-5; WLHUM, MACA, Council Minutes, 9 July and 2 December 1931.

¹⁸³ WLHUM, MACA, Press Cuttings from Album, 'Suggestions of the Sub-Committee on the Extension of the Work of the After-Care Association, March 9 1904'.

¹⁸⁴ Registers suggest that cases chargeable to Leicester and Loughborough (and treated in Leicester Asylum) were sent to Southsea, Hampshire (respectively c.127 and c.137 miles away). Cases treated in Hayward's Heath in Sussex, but chargeable to Derby similarly went to homes in the south-east (one to Hassocks, Sussex: c.148 miles). WLHUM, Registers, 5605 (Augustus L), 10 January 1918; 5804 (F.J.B. S), 6 June 1918; 6703 (Robert E), 15 April 1920; 8809 (Hannah L.C. J), 7 February 1924. Devon and Wiltshire also sent patients considerable distances to the central MACA's homes in the 1920s. WLHUM, MACA, *Annual Reports*, 1925, pp. 10-11; 1928, pp. 11-12.

that the MACA may have taken the distance between convalescents and their support networks into consideration. When the charity considered where to house Ada L. H during her convalescence, they decided she was 'to be lodged near to her sister if possible'.¹⁸⁵ Correspondence between Mrs Balls and the MACA in 1916–17 suggests patients may have held similar concerns over their future destination for work. After a job Mrs Balls had found for Alice T in the country came to nothing, Balls wrote that she appeared 'really pleased she is not going so far away', as she was 'anxious to stay near Miss Barnsley'.¹⁸⁶ Distance perhaps mattered less in other cases. Kathleen O, for example, requested the MACA find her work 'away' from her mother's home in Plymouth, yet appeared 'very happy' to the MACA when she later returned for a holiday.¹⁸⁷

Reported discussions between Laura F and her mother suggest some patients and their families may have adopted a strategic approach to convalescence, and tacitly welcomed the temporary hiatus it provided. Mrs Balls wrote to the MACA in December 1916 that while Laura F was 'as pleased as I am' that she would be staying in the convalescent home for 'a little longer'. While she apparently declared to Balls that she was 'very much looking forward to seeing her mother soon', she also made it plain that she did 'not wish to reside there [at her mother's house] altogether' and instead sought her own employment. It seems, therefore, that Laura regarded both convalescence, and the anticipated return to her mother that would follow, as

¹⁸⁵ WLHUM, MACA, Registers, 1207 (Ada L. H) 12 October 1910.

¹⁸⁶ This may refer to Miss Bardsley, the rescue worker who had initially referred Alice's case to the MACA. WLHUM, MACA, Case Files, 5109 (Alice T), Mrs Balls (Cottage Home Matron) to MACA, 30 December 1916.

¹⁸⁷ *Ibid.*, 1 September 1916 and 18 June 1917.

welcome but temporary steps on the road to independence.¹⁸⁸ In turn, Laura's mother also seems to have condoned her daughter's convalescence, whilst also fondly anticipating her return. While she had apparently written to Mrs Balls that she was 'looking forward to having her "Laura" with her for Xmas', when this was vetoed, Laura's mother encouraged the Association to keep her 'for as long as possible'.¹⁸⁹ This suggests how some patients and families may have accepted the need for convalescence, and perhaps welcomed it, though without access to similarly extensive correspondence for other cases it is hard to determine the typicality of these responses. Through the mediated account of Mrs Balls, it is also possible to discern a tension between Laura and Alice's cooperativeness within her home, and their impatience for release. Although Mrs Balls noted both Laura and Alice had proven 'very helpful... and really nice', she had already raised aspects in each case of resistance to extended convalescence.¹⁹⁰ Alice had expressed her disappointment 'at the idea of going to another home' when Mrs Balls raised her planned relocation to new premises, while she also observed that Laura had seemed 'a wee bit disappointed at not being able to go home on Xmas'.¹⁹¹

These two cases hint at the contested sense of belonging patients may have felt, between a desire for independence, attachment to carers in the community, and a need for a temporary period of convalescence. Case-files suggest patients such as Alice T felt impatience as they anticipated a

¹⁸⁸ WLHUM, MACA, Case Files, 5109 (Alice T), Mrs R. Balls (Matron of cottage home at Hextable, and later New Elmham) to Ethel Vickers (Secretary, MACA), 10 and 31 December 1916.

¹⁸⁹ Ibid., 10 December 1916.

¹⁹⁰ Ibid., Mrs R. Balls to Ethel Vickers, 16 December 1916.

¹⁹¹ Ibid., Mrs R. Balls to [MACA], 8 and 19 December 1916.

return to work, but further indicate the apprehension that others like Laura may have felt towards supporting themselves again. Mrs Balls reported that 'what worried' Laura was whether the MACA would help her find work afterwards, which provides a rare glimpse into the hopes and fears convalescents may have felt more widely. It appears Emma L proved reluctant to leave the security of Mrs Whittingham's home, as the MACA decided to offer 'another situation' if she 'refused to leave the home'. The exact circumstances in this case are unclear, yet the resistance this patient displayed to plans for her departure suggests that she preferred convalescence to independence.¹⁹² Patients occasionally refused work found for them after convalescence, and therefore appear more self-reliant, though the case-records rarely indicate why they made such refusals.¹⁹³ It is easier to discern a desire amongst some patients who were apparently restless to enter employment. Alice T justified her disappointment at moving to another cottage home on the basis that she 'had hoped to go straight into a situation'; a desire she repeated after relapse and readmission to an asylum. In this rare firsthand letter from a patient, Alice wrote that she was 'longing' to get out 'and earn my own living again'.¹⁹⁴ Ernest S requested to look for work during his convalescence whilst Ellen R appeared 'very pleased' that MACA had looked for work on her behalf, according to her matron.¹⁹⁵

As Allan Beveridge has identified among asylum patients at Morningside, convalescents in the MACA's homes reacted dynamically and

¹⁹² WLHUM, MACA, Registers, 6878 (Emma L), 29 July 1920.

¹⁹³ Ibid., 5841 (Emma B), 18 July and 19 September 1918.

¹⁹⁴ WLHUM, MACA, Case Files, 5109 (Alice T), 10 December [1916].

¹⁹⁵ Ibid., 4118 (Ernest S), 19 December 1914; 4417 (Ellen Margaret R), 13 April 1915.

changeably to their environment and carers.¹⁹⁶ Florence H relapsed a few days after she refused to stay in Mrs Hegerty's cottage home, and entered Brookwood Asylum, from which she also escaped in June 1914. On being offered convalescence after referral from another asylum in August 1916, however, Florence reacted more positively, and eventually wrote that she had been 'very happy with Mrs Price and had got on well'.¹⁹⁷ The emphasis Florence placed on her relationship with Mrs Price indicates the importance patients may have attached to their relationship with matrons and others in the home, in providing a sense of belonging. Such attachment appears equally important among those later placed in service. Several left after conflict with their first employer, but like Ellen R, who the MACA described in 1915 as 'much happier' in her second situation, sometimes displayed more contentment in subsequent domestic placements.¹⁹⁸ While case-files tend to present patients in isolation, inspection reports hint at the operation of group dynamics within homes, and collective responses to convalescence. 'C.W.' who visited Mrs Foster's home on 26 September 1941 interviewed most residents together, as they sat in the home's sitting room, and reflected upon their behaviour as a group, when she commented 'I hope they will settle down again now'.¹⁹⁹ Two months later the inspector considered the similar responses patients exhibited to their care. Their remark that 'all seem to have their ups and downs' suggested that they perceived comparable

¹⁹⁶ Beveridge, 'Life in the Asylum', p. 449.

¹⁹⁷ Mrs Price was the matron, who took Florence H into her cottage home at Langley. WLHUM, MACA, Case Files, 4049 (Florence H), 22 July and 30 September 1916; WLHUM, MACA, Agenda Case Books, 11 and 25 June 1914.

¹⁹⁸ WLHUM, MACA, Case Files, 4417 (Ellen Margaret R), 14 May and 1 June 1915. See also: WLHUM, MACA, Case Files, 4052 (Elizabeth S), 26 August, 23 September, 15 and 29 October 1914, and 17 August 1915; 5031 (Alice C), 2, 5, 12 and 29 January, and 26 June 1917.

¹⁹⁹ WLHUM, MACA, C.W., inspection report on Mrs Foster's home, 26 September 1941.

fluctuations in patient reactions, which like Florence H's evidently variable emotions, may have changed over the course of their treatment.²⁰⁰

Alice T's case file illustrates the role ongoing relationships and changing circumstances may have played in patient's attitudes to convalescence. Following her placement as a housemaid after convalescence in 1918, Alice's opinion of her new employer deteriorated from 'Mrs [Q]uick is a very merry woman herself', to 'she is an awful woman', in little over a month.²⁰¹ This case exemplifies Allan Beveridge's point on the transience of the emotions patients expressed, whether joy, anger, or despair, at their circumstances.²⁰² Disagreements with employers in several cases reveal the rapidity with which patients' hope for a new life were replaced with other emotions, as they attempted to adapt to the pressures of working life.²⁰³ After her initial eagerness to return to work in 1916, Alice returned for convalescence in 1918, and wrote how glad she was that the doctors had given her 'another chance', and felt 'very happy' in the home.²⁰⁴ Mary P's case in particular illustrates how patients may have been aware of their own inconsistent responses to the treatment they had received. Hers is the only case among those years surveyed in the pre-1925 case records whose edited account on her treatment later appeared in post-1931 annual reports. In her letter to the Association sent in 1935, Mary recognised her past 'empty talk about not wanting to live or carry on', and 'one or two

²⁰⁰ Ibid, 27 November 1941.

²⁰¹ WLHUM, MACA, Case Files, 5109 (Alice T), 8 January and 12 February 1919.

²⁰² Beveridge, 'Life in the Asylum', p. 462.

²⁰³ WLHUM, MACA, Case Files, 4052 (Elizabeth S), 26 August 1914, 15 and 29 October 1914, 17 August 1915; 4110 (Camilla N), 20 October 1914; 5001 (Annie H), 18 September 1917; 5031 (Alice C), 29 December 1917.

²⁰⁴ Ibid., 23 October 1918, letter from Alice T (convalescent patient) to Ethel Vickers (Secretary, MACA), 23 October 1918.

relapses', but also emphasised her present cheerful stability.²⁰⁵ This at once distanced her from her former depression, but in her claim that the Association had given her 'the strength required' to persevere, also alluded to the contingency of her present wellness.²⁰⁶

Experience of working life, and difficulties associated with reintegration into the community encouraged patients to return to both mental hospitals and the MACA after their discharge. In contrast to escapees, some like Ernest S voluntarily chose to return to their former cottage homes for further convalescence. Having worked briefly as a plumber, the MACA reported Ernest had found the work 'too hard', and re-entered Mr Wood's home, on the charity's condition that it could only last two weeks.²⁰⁷ Kathleen O similarly returned for convalescence, and chose to maintain regular contact with the Association, through visits and regular and voluminous correspondence between 1916 and 1924.²⁰⁸ Other discharged cases, who had the option to leave, also returned to cottage homes at a later date.²⁰⁹ Equally, after 1931 hundreds of voluntary patients acquiesced to convalescence.²¹⁰ It is likely that other patients identified mental hospitals as a home, especially when they had spent several years within these

²⁰⁵ Registers show that in the period examined for this chapter, Mary went to a cottage home in both November 1910 and March 1914. WLHUM, MACA, Registers, 23 November 1910, 5 March 1914, 14 March 1914.

²⁰⁶ WLHUM, MACA, *Annual Report*, 1935, p. 10, case 3094.

²⁰⁷ WLHUM, MACA, Case Files, 4118 (Ernest S).

²⁰⁸ *Ibid.*, 4993 (Kathleen O).

²⁰⁹ E.g., WLHUM, MACA, WLHUM, MACA, Agenda Case Books, 5998 (Emily Lilian H), 31 October 1918; 3 April 1919, 29 March 1923; 1866 (Harriet L), 19 December 1918, 17 December 1924; 6837 (William B), 15 April, 20 May, and 29 July 1920; 7924 (Emily Florence N), 9 February and 28 May 1922.

²¹⁰ WLHUM, MACA, Council Minutes, 1913-15, 1917-20, 1927-40, SA/MAC/C.2/1-5, 16 September 1931; Roof, *Voluntary Societies and Social Policy*, pp. 118-9.

institutions.²¹¹ The case of Miss H, suggests how patients may have sought refuge in the relatively familiar environment of the asylum. Although *John Bull's* journalist who reported her case attacked an asylum system that had 'buried alive' and 'lost' Miss H for thirty years prior to her discharge, the article suggested she had actively sought-out re-institutionalisation. It blamed her relapse after discharge from Horton Hospital in December 1928 on financial worries and difficulties in making the 'readjustments' necessary for life in the wider community. These, the article claimed, provided the 'impulse' for Miss H to 'fly from a heartless world back to the asylum where she had at least been cared for and respected'.²¹² While some sought escape from both asylums and cottage homes, therefore, others may have felt sufficient attachment to these institutions that they sought to return when circumstances necessitated.²¹³

Those able to return to their families and friends occasionally chose this instead of convalescence through the MACA. Disregarding Maurice Craig's advice in person, Esther Lydia M refused to leave her child in 1918, and as a result the MACA reported, 'cannot be convalesced'. It appears from a later record that Esther did go to a cottage home at Hurstpierpoint after this initial resistance. As with many other convalescents, Esther later relapsed, which raised the possibility she might face similar choices in the future.²¹⁴ It

²¹¹ Chris Philo, 'Scaling the Asylum: Three Geographies of the Inverness District Lunatic Asylum (Craig Dunain)', in Leslie Topp, James E. Moran and Jonathan Andrews (eds), *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (Abingdon, Oxon, and New York: Routledge, 2007), pp. 116-8.

²¹² WLHUM, MACA, Press Cuttings from Albums, 'Buried Alive for Thirty Years: A Staggering Asylum Story', *John Bull*, 21 July 1928.

²¹³ Diana Gittins has suggested that some convalescent wards at Severalls served as refuges for exhausted women. See Gittins, *Madness in its Place*, pp. 131-2.

²¹⁴ WLHUM, MACA, Agenda Case Books, 5378, (Esther Lydia M), 31 January 1918 and 30 December 1920.

appears from Ellen R's case-file that other patients only reluctantly undertook convalescence based on need: Ellen only agreed to convalescence after the MACA had first sent an ultimatum to the effect that they would only assist in finding her employment if she first went to a cottage home. Although she agreed to go, Ellen attempted to leave after a month. Her frustration is palpable in the record the MACA made of her letter, in which she stated she wanted 'to know what she was to do as she could not stay on at Mrs Bleach's'.²¹⁵ While some patients endorsed the MACA's view that cottage homes provided a familial environment, therefore, others evidently felt little sense of belonging or attachment to their temporary carers. Once in homes, some actively rebelled against their temporary placement. On her first placement in a cottage home in 1914, Florence H's matron reported she had threatened to commit suicide 'if prevented from going back to her friends'.²¹⁶ After she had run away from Mrs Hegerty's cottage home in June 1914, Florence had told police she 'did not wish to return' to the home, but asked instead to be 'sent to the Workhouse'.²¹⁷

In this case, the file indicates that Florence H felt she had another place she could return to and belonged, outside the managed home environment the MACA offered her as a convalescent patient. It seems, therefore, that patients who felt responsibilities towards their families, wanted to commence work, or who had places or people they felt able to return to, sometimes perceived cottage homes as an inferior option to other 'homes' in

²¹⁵ Mrs Bleach was the matron, who took Ellen R into her cottage home at Horsham. WLHUM, MACA, Case Files, 4417 (Ellen Margaret R), [oblit], 18 and 19 March 1914, 26 April 1915.

²¹⁶ Allan Beveridge has suggested institutionalised patients may have threatened to commit suicide more widely, as a response to their committal. See Beveridge, 'Life in the Asylum', p. 442.

²¹⁷ *Ibid.*, 4049 (Florence H), 12 and 13 June 1914.

the community. As these cases illustrate, patients occasionally made concerted attempts to leave the MACA's homes, and return to the community. On the evidence of the MACA's registers, escapees comprised only a small minority of all cases offered convalescence. Nevertheless, registers recorded six cases in 1924 alone that had run away or 'disappeared' from the charity's homes.²¹⁸ Registers and minutes suggest such departures formed a recurrent theme in the MACA's casework. At the least, friends provided an alibi for those such as Herbert K (case 23182), who failed to return to a MACA cottage home in 1938 after he 'left... to meet a friend at 1.30pm'.²¹⁹ During the First World War, Lena S illicitly met with soldiers, and then had escaped from the cottage home disguised in the matron's own clothes.²²⁰ After her placement in service, Gertrude W similarly took furs from a woman in the same village, and left to meet an acquaintance that the MACA had earlier during her convalescence described as a 'bad influence', and instructed her to avoid.²²¹ While the reality, identity and relationship of patients' friends is in other case less clear, it is significant that many convalescent and aftercare patients used real or purported relationships with those outside homes as a means to return to wider society.

Mary Riggall's account of her time as a mental hospital patient in the early 1920s suggests institutionalised patients and staff may already, in

²¹⁸ WLHUM, MACA, Agenda Case Books, 8809 (Hannah L.C. J), 7 February 1924; 9644 (Jessie S), 20 March 1924; 9556 (Frederick B), 9 April 1924; 9575 (Alfred Casey C), 9 April 1924; 10057 (Barbara Elsie F), 4 September 1924; 9157 (Nellie F), 12 September 1924.

²¹⁹ LMA, LCC, Cane Hill Mental Hospital Presented Papers, 1938-9, LCC/MIN/905, 2 June 1938, report by Medical Superintendent, p. 3.

²²⁰ WLHUM, MACA, Case Files, 5375 (Lena S), [n.d., c. 1917-18].

²²¹ *Ibid.*, 4154 (Gertrude Emmeline Decima W), 8 December 1914, 8 October 1915.

some cases, have shared knowledge on options for escape.²²² Escape was only relevant for those on trial periods, who under the Lunacy Act, 1890, remained officially certified and the responsibility of mental hospitals whilst in the community. Trial became an increasing part of the MACA's convalescent workload. On the evidence of the charity's records, at least 58.4 per cent (205) of the 311 individuals accepted for convalescence during 1924 were trial patients. This marked a substantial shift towards those still under certification in little over a decade since the MACA had first accepted them in 1913.²²³ Those like Herbert K and Robert James T who 'escaped' while on trial with the MACA, therefore formed part of a burgeoning subset of patients, for whom convalescence represented the continuance of supervision managed for legal as well as medical and social reasons.²²⁴ Stories and experiences of fleeing shared within mental hospitals may have influenced patients' decisions about whether they attempted to leave care during their trial period. Riggall later claimed that she had decided against escape from her mental hospital with another patient after a nurse told her that such cases were generally 'soon found and brought back'.²²⁵ The extent to which patients discussed parole and trial privileges within the asylum can also be gauged from John Vincent's observation that 'every' patient 'coveted' parole. This suggests that patients may have reflected upon the benefits such freedoms brought, while some like Lawrence Jayson would already have

²²² Riggall, *Reminiscences*, p. 15. See also Gittins on the knowledge shared between staff and patients on the law on escapes in the 1950s. Gittins, *Madness in its Place*, p. 166.

²²³ These figures are based on those cases that the MACA identified as 'on trial' in its Agenda Case Books. Because this was entered manually under 'comments', rather than ticked on a pro forma table, the proportion of trial patients might feasibly have been higher, though the figures demonstrate that this information was entered in the majority of cases. WLHUM, MACA, Agenda Case Books, 1924.

²²⁴ *Ibid.*, 7013 (Robert James T), 29 July 1920;

²²⁵ Riggall, *Reminiscences*, p. 15.

experienced or witnessed the withdrawal of privileges for unauthorised stays outside the asylum.²²⁶

Suicides provided a rarer and more unilateral exit from institutional treatment. Historians have noted the relatively low suicide rate within nineteenth- and twentieth-century asylums and mental hospitals compared against rates in the community, and speculated whether suicide rates rose amongst those discharged.²²⁷ Registers recorded two cases where patients committed suicide between 1918 and July 1925, and a third who later 'died', though in this period none appears to have done so in the charity's homes.²²⁸ Within the short time that patients stayed within the MACA's homes therefore, the available evidence suggests few patients took their lives immediately after discharge under the charity's supervision. Nevertheless, psychiatrists involved with the MACA perceived suicide as a particular risk in convalescence, especially among depressed patients.²²⁹ Henry Yellowlees stated that most suicides occurred in the 'early' stages of convalescence in

²²⁶ John Vincent, *Inside the Asylum* (London: George Allen and Unwin, 1948), p. 98; Jayson, *Mania* pp. 192-3. Writing on parole in the *Journal of Mental Science* suggests medical superintendents in England and Scotland allowed parole to patients in the 1910-20s, based on a promise by the patient that they would not try to escape. See T.E. Knowles Stansfield, 'The Villa or Colony System for the Care and Treatment of Cases of Mental Disease', *Journal of Mental Science* **61** (January 1914), p. 32; George M Robertson, 'The Hospitalisation of the Scottish Asylum System', *Journal of Mental Science* **68** (October 1922), p. 327.

²²⁷ Allan Beveridge, 'Madness in Victorian Edinburgh: A Study of Patients Admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873-1908, Part II', *History of Psychiatry* **6**:2 (1995), p. 143; Diana Gittins, 'Silences: The Case of a Psychiatric Hospital', in Mary Chamberlain and Paul Thompson (eds), *Narrative and Genre* (London and New York: Routledge, 1998), pp. 53-4; Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', pp. 176-7, 194; Sarah Hayley York, 'Suicide, Lunacy and the Asylum in Nineteenth-Century England (unpublished PhD thesis, University of Birmingham, 2009), pp. 175-7.

²²⁸ WLHUM, MACA, Agenda Case Books, 5630 (Eleanor M. G.), 31 January and 4 April 1918; 6475 (Harry D.), 7 August 1919; 4895 (William Jonathan H. G.), 23 March and 4 May 1922.

²²⁹ Savage, *Insanity and the Allied Neuroses*, p. 207; Henry Yellowlees, *Clinical Lectures on Psychological Medicine* (London: J. & A. Churchill, 1932), p. 32. Savage hosted the MACA's annual meeting at his home in 1909, and had spoken at the Association's meeting the previous year, while he acted as the charity's Treasurer between 1896-c.1921. Yellowlees became the MACA's chairman in 1939.

depressives, which he considered it the physician's responsibility to prevent.²³⁰ E.U.H. Pentreath and E. Cunningham Dax of the LCC, which made considerable use of the MACA's homes (see Chapter Three), endorsed their use for a depressive case who, 'perhaps after a suicide attempt', required further supervision.²³¹ Likewise, the almoner at Westminster Hospital reported in 1932 how the MACA had consistently supported their cases of 'attempted suicide' when other convalescent homes refused them admission.²³² Although infrequent, when deaths occurred they prompted policy change and considerable debate over the respective role of referrers, matrons and the MACA in mitigating recurrences in the future. After two patients died in its homes in 1937–38, the charity wrote to superintendents and all matrons on their responsibilities in providing notification of risk, and changed its forms to better gather relevant information.²³³ Furthermore, following coroners investigations, the MACA decided to refuse recent suicidal cases 'until sometime had elapsed after the attack [*sic*].'²³⁴

The MACA's reliance on superintendents' and carers' observations on the likelihood of suicide indicate the extent to which convalescents' belonging was contingently determined on the basis of ongoing observation by a number of interested parties. Shepherd and Wright have argued that Victorian superintendents preferentially discharged patients once the

²³⁰ Yellowlees, *Clinical Lectures*, p. 32.

²³¹ E.U.H. Pentreath and E. Cunningham Dax, 'Mental Observation Wards: A Discussion of their Work and its Objects', *Journal of Mental Science* **83** (July 1937), p. 359

²³² WLHUM, MACA, Press Cuttings from Albums, extract from *Report of the Almoner's Department, Westminster Hospital*, 1932.

²³³ WLHUM, MACA, Council Minute Resolution Books, 1921-39, SA/MAC/C.2/3, 17 December 1937 and 14 January and 18 March 1938.

²³⁴ *Ibid.*, 25 February 1938.

likelihood of self-harm had abated.²³⁵ After 1913, however, superintendents could choose to place trial patients who legally required further supervision and posed a risk to themselves or others in the MACA's homes.²³⁶ The LCC Mental Hospital Committee produced 'Directions' in 1926 on the management of trial patients, which recognised the 'threatened or attempted violence' such cases might display. In these cases the LCC endorsed the MACA's earlier conclusion in its 'Rules for Matrons' of 1914 that cases should be referred to superintendents for re-institutionalisation.²³⁷ It appears, however, that in practice carers and the MACA may have independently assessed where convalescents who threatened violence belonged, as illustrated in two divergent cases on their files. Whereas the MACA advised Mrs Hergarty to allow Florence H to leave after she threatened to kill herself, the matron in Edith Vere E's case acted swiftly to return her to the asylum.²³⁸ The MACA's constitution prevented it from direct engagement with the recertification of discharged patients and re-committal of trial patients who threatened suicide in its homes. Instead, it placed these responsibilities on its matrons.²³⁹ Consequently, in one scenario, the matron interpreted suicidal intent as a symptom of madness, yet in the other the MACA advised the matron to regard it less seriously, as a strategic demand for release.

²³⁵ Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', p. 194.

²³⁶ See Chapters Two and Three.

²³⁷ LMA, LCC, Horton Hospital Sub-Committee Minutes, 1919-49, LCC/MIN/1140-54, 5 February 1926, p. 92, on 'Directions as to the Care of Patients Out on Trial' agreed by Mental Hospitals Committee 26 January 1926.

²³⁸ WLHUM, MACA, Case Files, 4049 (Florence H), 12 June 1914, and 4897 (Edith Vere E), 22 and 23 November 1916.

²³⁹ Under its constitution, the MACA refused to take part in re-certification procedures, which it left to its matrons. See WLHUM, MACA, Propaganda Committee Minute Book, 1921-9, SA/MAC/C.4/4, WLHUM, MACA, c.1914, 'Rules for Matrons for Cases on Trial'.

Attacks on the self and cottage home subverted the tranquil, restful and sociable environment the MACA intended to create, though it is harder to attach motive or cause to patients' actions. Independent and disruptive actions, however, had an effect on belonging, even when the impetus behind them remains contestable. The momentary destructiveness of one patient, who set fire to his bedding and broke a gas meter at a cottage home in 1938, suggests little about the patient himself. Nevertheless, regardless of intent, such actions implicitly challenged the harmonious domestic idyll the charity promoted during convalescence.²⁴⁰ As with those who displayed active suicidal impulses, the MACA screened patients on the basis of their behaviour, and in the case of Ethel K., made cottage home convalescence dependent on 'reformed' conduct.²⁴¹ Kathleen O attributed what she considered bad (occasionally 'wicked') behaviour, such as letter-tearing, and unannounced visits at the MACA's office, to an *alter ego*. The poignant name given to this identity – 'Miss Dignity' – evoked an integral self-worth, despite Kathleen's apologies for her *alter ego* Dignity's conduct. The connection between this identity and independent action, which occasionally provoked the ire of the MACA's workers, suggests a tension between Kathleen's desire to behave, and Dignity's desire to wilful independence. While it was Kathleen who initially resisted sanatorium treatment in September 1917, a subsequent entry claimed Dignity 'does not want to go either'. Later, the MACA recorded it was "' Miss Dignity" who does not want to stay any longer at Clacton!' The atypical exclamation mark and inverted commas in this record, indicate that the MACA only partially recognised Dignity as a separate entity, despite

²⁴⁰ WLHUM, MACA, Council Minutes, 25 February 1925.

²⁴¹ WLHUM, MACA, Registers, 5480 (Ethel K), 18 July 1918.

Kathleen's claim they represented different characters.²⁴² Consequently, Kathleen's *alter ego* Miss Dignity challenged the MACA both through her actions, and her very claims to existence.

5. Conclusion

Patient responses to treatment between 1910 and 1939 suggest that the unitary classification 'convalescence', and the solid structures set aside for its management, concealed diverse interpretations of its function. Indeed, through their refusals, escapes and appeals for early discharge, some patients contested with those who provided institutional convalescence whether it had any ongoing value to them at all.²⁴³ In contrast, the voluntary returns to cottage homes and letters of thanks patients sent, suggests others accepted convalescence as a worthwhile and perhaps necessary precursor to their full independence. As such, patients were important interpreters of mental recovery, who evaluated its relevance and meaning within the fluid medical and social contexts of their own lives. To some extent, spaces created for mental convalescence do seem to have shaped normative expectations of the duration, location and content of practices designed to promote recovery.²⁴⁴ Repeated references to rest, change, diet and matrons' kindness in patients' letters suggests some at least assimilated the therapeutic rationales for convalescence the MACA and medical superintendents promoted (Chapters Two and Three). At the same time,

²⁴² Ibid., e.g., 3 July 1919.

²⁴³ Biswamoy Pati, Chandni P. Nanda, 'The Leprosy Patient and Society: Colonial Orissa, 1870s-1940s', in Pati Biswamoy and Mark Harrison (eds), *The Social History of Health and Medicine in Colonial India* (Abingdon, Oxon; and New York: Routledge, 2009), pp. 121-3.

²⁴⁴ Philo, 'Scaling the Asylum', p. 116.

however, patients frequently represented the totality of these elements as a 'holiday', as Jenny Cronin has found in contemporary general convalescent homes in Scotland.²⁴⁵ Consequently, these patients applied a predominantly social interpretation to convalescence, which viewed it as a break from the demands of work and social activity, rather than the final stage in the medical treatment providers promoted. Behind the apparently unified organisational and material plans for convalescence, therefore, providers and recipients sometimes held divergent understandings on its significance. Its definitional coherence and vitality as a medico-social category, as Ian Hacking has argued for classifications more generally, depended upon a consistency between providers and recipients' interpretations, which appears to have only partially existed.²⁴⁶

The descriptions patients applied to their treatment, and the allusion some made to purposefully forgetting, suggest how some ex-convalescents may have sought interpretive power over their memories of illness and recovery.²⁴⁷ While Allan Beveridge has argued that retrospective accounts tend to 'distort' ex-patient's memories of their institutionalised lives, they accurately reflect the desire some patients felt to make sense of their past.²⁴⁸ The idea that convalescence represented a 'holiday' resituated the patient in the context of their former social lives, and allowed the patient to recall the friendly associations and common pleasures they had enjoyed in the cottage home. In contrast, it seems those who petitioned for their release from

²⁴⁵ Cronin, 'Scottish Convalescent Homes', pp. 223-7.

²⁴⁶ Hacking, *Social Construction of What?*, pp. 31-4; Ian Hacking, 'Making Up People', *London Review of Books* 28:16 (August 2006), pp. 23-6.

²⁴⁷ Davies, 'Silent and Censured Travellers', p. 226; Gittins, 'Silences', p. 46; Leed, 'Fateful Memories', pp. 86-7.

²⁴⁸ Beveridge, 'Life in the Asylum', p. 461.

asylums may have bypassed notions of convalescence, and alternately looked forward to discharge directly into the community. Extant case-files suggest the difficulties patients may have experienced in acclimatising to new jobs, while registers indicate that even after convalescence, many relapsed and returned to the Association. In the light of this evidence, it is likely autobiographical accounts and patient letters under-represent the experiences of those that the MACA's registers suggest did not prosper after discharge.²⁴⁹ In these cases, patients may have been glad to forget entirely. Lawrence Jayson's sensitivity to other patients in his mental hospital who had 'completely buried those chapters of their lives and... had no wish to revive them', indicates that many may have preferred to erase rather than interpret their memories of recovery.²⁵⁰ The majority of convalescents left no independent record of their experiences, and are only known through a brief entry in the MACA's registers. Their silence provides mute testimony to the highly personal interior memories former patients are likely to have held, beyond the reach of the historical record.

How far patients felt a sense of belonging within convalescent homes appears to have depended significantly on their relationship with matrons within the home, and friends, families and carers in the wider community. In contrast to the emphasis several historians have recently placed on the 'affection' between families and their institutionalised relatives, it appears in a number of cases the MACA provided help precisely due to the lack of those

²⁴⁹ Grant-Smith, *Experiences of an Asylum Patient*, pp. 54, 59; King, *Recovery of Myself*, pp.131, 134-5; Jayson, *Mania*, pp. 158-67; Woodley, *Certified*, pp. 11, 221; Porter, *Faber Book of Madness*, p. 519.

²⁵⁰ Jayson, *Mania*, p. 7.

outside willing to help.²⁵¹ In one case where a convalesced patient's wards gave a bad account of her conduct to her new employer, the MACA responded that 'relations often gave a worse account than was really right'.²⁵² Cases of domestic abuse, and the desire of convalescents to find work in new locations equally challenge the idea that patients would have necessarily looked forward to a return 'home'. The voluntary contact other patients made to cottage homes, as visitors, correspondents, or relapsed cases, meanwhile, suggests that some felt sufficient belonging there to keep in touch, and where necessary, return for further temporary care. Whether for strategic reasons, or for the want of other options, patients therefore demonstrated an attachment to cottage homes. Nevertheless, Laura F's case, and others whose relatives agreed to take them back after convalescence, supports the idea that families and friends sometimes withheld care, even whilst they anticipated their relative's eventual return. While some families and spouses permanently distanced themselves from their newly convalescent relations, therefore, others kept in touch, planned their discharge, and repaid their costs.²⁵³ This suggests that kinship groups may have actively cooperated in a system designed to keep patients outside the family home, beyond their participation in asylum committal and

²⁵¹ Smith, 'Your Very Thankful Inmate', p. 250; Suzuki, *Madness at Home*, pp. 113-5, 119; Thomson, *Problem of Mental Deficiency*, p. 263.

²⁵² WLHUM, MACA, Case Files, 4049 (Florence H), 8 September 1916.

²⁵³ This suggests families remained involved in patients' convalescent periods, as well as intervening in asylum care, as other historians have suggested. See Louise Wannell, 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910', *Social History of Medicine* **20** (September 2007), 297-313; Coleborne, 'Challenging Institutional Hegemony'.

discharge that David Wright, Akihito Suzuki and Mary Fisher have examined.²⁵⁴

Patient trajectories after their discharge to convalescence varied significantly, and influenced how patients interpreted their recoveries and their sense of belonging during convalescence. Relapses and recurrent periods of recuperative treatment, perhaps compromised the implicit assumption that convalescence could sustainably ensure permanent recoveries. Case-files suggest that patients sometimes viewed convalescence more warmly upon their readmission, but this return itself would have made it harder for them to regard convalescence as a pivotal turning-point.²⁵⁵ Where more information on individual patients is available, as with Alice T or Albert Francis N, it appears patients held multi-focal senses of belonging, which fluctuated according to their health, prospects and attachments to particular people. Both patients had sustained contact with the MACA, significantly beyond the period providers allocated for the 'half-way home' of convalescence. Whereas Jonathan Andrews has argued that asylum case-records tend to ignore the contexts of patients' lives before or after discharge, aftercare and psychiatric social work prolonged patients' contact with those with interests in their recoveries.²⁵⁶ The MACA aimed to help patients find and remain in employment, which Vicky Long and Peter Barham have suggested may have been imposed as a precondition of convalescence. However, solicitations from patients for work suggest that in some cases at least, patients may have reinforced the idea that employment

²⁵⁴ Suzuki, *Madness at Home*; Wright, 'Getting Out of the Asylum', pp. 150-1; Fisher, 'Getting Out of the Asylum', pp. 137, 224-6.

²⁵⁵ E.g., WLHUM, MACA, Case Files, 5109 (Alice T); 4417 (Emma Margaret R).

²⁵⁶ Andrews, 'Insanity at Gartnavel', p. 263.

was a desirable outcome and part of their process of recovery.²⁵⁷ Patients could choose to some extent to make sense of their own recoveries, even though the services made available to them also in turn shaped their expectations.

²⁵⁷ Long, 'Changing Public Representations of Mental Illness', pp. 190-1; Barham, *Forgotten Lunatics of the Great War*, p. 24.

Conclusion

The period between 1919 and 1939 witnesses the emergence of a more coordinated and standardised system of convalescent treatment for mental patients. Within mental hospitals, the London County Council's (LCC) experiments from the 1900s with paired admission hospitals and convalescent villas, increasingly became an expected part of the modern mental hospital. These connected recovery with early treatment, reflected in their designation as 'early treatment centres' by the late 1930s.¹ Outside, voluntary cottage homes after the First World War similarly began to offer convalescence for early care cases, whose psychiatric troubles and subsequent treatment were therefore brought into the orbit of the mental hospital system, even though managed in the community. Together, these convalescent villas and cottage homes formed part of what historians such as Roy Porter have recognised as a broader early twentieth-century concern with prevention, mental hygiene and early treatment.² Indeed, the coextensive spread of homes for convalescents both within and outside the mental hospital, suggests that the 'gap' planners sought to bridge through half-way homes expanded significantly in the interwar period. The extension of voluntary cottage home convalescence to trial patients (1913) brought those still under asylum supervision into the community; conversely, the extension of similar homes to early care cases (1917; 1924) introduced

¹ The Board of Control had begun to refer to a combination of admission hospitals and convalescent villas as 'early treatment centres' by 1937. See BoC, *Annual Report*, 1937, p. 23; BoC, *Suggestions and Instructions for the Arrangement, Planning and Construction of Mental Hospitals* (London: H.M. Stationary Office, 1941), p. 5; F.C. Webster, 'Modern Trends in the Planning of Mental Hospitals and other Psychiatric Units in England', *Journal of Mental Science* **44** (January 1948), p. 100.

² Roy Porter, 'Two Cheers for Psychiatry!: The Social History of Mental Disorder in Twentieth-Century Britain', in Hugh Freeman and German Berrios (eds), *150 Years of British Psychiatry Volume II: The Aftermath* (London: Athlone, 1996), p. 393.

convalescence to those who had never left the community. Mental hospitals mimicked this community-based approach to treatment. Under pressure from the BoC, local authorities increasingly added paired admission hospitals and convalescent villas, that placed convalescents further from the old 'asylum', and ideationally and often physically closer to the community beyond.

This thesis has challenged a view amongst historians that the twentieth-century mental hospital differed little from the nineteenth-century asylum. While Andrew Scull and Edward Shorter have argued psychiatrists increasingly abandoned mental hospitals in the early twentieth century, admission and convalescent units built in this period arguably formed part of their longstanding attempt to make these institutions more like general hospitals.³ Scull and David Cochrane have largely dismissed the significance of additional villas built from the 1900s.⁴ In contrast, Chapters One and Two have indicated that new buildings were central to claims that the mental hospital remained not only a viable site for treatment, but moreover a reformed and essentially 'modern' institution. Outwardly, the convalescent villa closely resembled nineteenth-century antecedents in its small-scale, homeliness, and open-door policies that asylum planners such as J.T. Arlidge and the Lunacy Commission had promoted from at least the 1850s. Such units, however, gained a new form and significance in the interwar era,

³ Andrew Scull, *Decarceration: Community Treatment and the Deviant – A Radical View* (Cambridge: Polity Press, 1984 [1977]), pp. 112-4; Andrew Scull, 'Psychiatry and Social Control in the Nineteenth and Twentieth Centuries', *Social History of Medicine* 2 (1991), p. 165; Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997), pp. 190-2.

⁴ Scull, *Decarceration*, pp. 112-4; David Cochrane, "'Humane, Economical, and Medically Wise": The LCC as Administrators of Victorian Lunacy Policy', in W.F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III: The Asylum and its Psychiatry* (London and New York: Routledge, 1988), pp. 266, 272.

as part of a reinvention of the asylum as the curative 'mental hospital'. The separate names, sites and access routes planned for convalescent villas distinguished them more clearly from the 'asylum', and resultantly bisected these institutions into recoverable and irrecoverable zones, much as gender had divided them in the nineteenth century. While Cochrane in particular has regarded interwar villas as simply an enlargement of essentially nineteenth-century accommodation, convalescent villas arguably formed part of a more symbolic shift of emphasis onto the newly-visible and visibly-separate recoverable patient.

Villas built within interwar mental hospitals consequently reflected a more substantial shift in ideas on how these institutions might function, even if in practice they probably served to rehabilitate the asylum more than patients themselves. Even in the nineteenth century, some like Ebenezer Toller partly justified cottages for convalescents as a remedy to the prejudice the public displayed against asylum treatment. Pressure for convalescent villas in the interwar period likewise seems to have stemmed partly from a desire amongst psychiatrists and the Board of Control (BoC) to present a reformed image of the interwar mental hospital. This is particularly evident in the modernising rhetoric the BoC in particular devoted to admission hospitals and convalescent villas. This served to obscure the continued detention of large numbers of chronic and acute patients in older central asylum buildings, and in turn collapsed the broader notion of the 'mental hospital' onto just a small part of the asylum site. A minority of mental hospital superintendents and local authority committees challenged the utility of convalescent villas, either overtly, or more implicitly through the alternative

provision of offsite homes. Others simply failed to construct new admission and convalescent units, although Steven Cherry's case-study of Norfolk documents one of relatively few not to have done so, whilst conversely Alexander Walk has overstated their universality by 1939.⁵ Virtually all local authorities had at least been called upon to consider their addition, however, and most had taken steps in this direction before the Second World War. Speeches, official circulars and reports, and psychiatric publishing, all promoted convalescent villas, through the idea that mental hospitals could reform through a more concerted attention of care towards the recoverable.

Convalescent villas and voluntary cottage homes can be seen as a strategic response to broader limitations imposed on institutional reform. A cumulative legacy of older buildings, and severe budgetary restrictions on capital expenditure in the economically depressed 1920 and 1930s, compromised the feasibility of plans for model asylums. Exceptions such as the Maudsley (1923) and Runwell (1937) perhaps indicate how asylum planners may have ideally pursued reform under more ideal conditions. The Maudsley's urban location, integrated clinic services, laboratories, and dedication to curative voluntary cases, and Runwell's home-like villas and psychotherapy, reflected psychiatrists' concerns to make asylums more accessible, and acceptable to the wider public.⁶ Under the Lunacy Act of 1890, however, even those local authorities in a position to build entire

⁵ Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum, St Andrew's Hospital, 1810-1998* (Woodbridge, Suffolk; and New York: Boydell, 2003), pp. 173, 206; Alexander Walk, 'Mental Hospitals' in F.N.L. Poynter (ed.), *The Evolution of Hospitals in Britain* (London: Pitman Medical Publishing, 1964), p. 11.

⁶ Malcolm Jeffries and J. Alfred Lee, *The Hospitals of Southend* (Chichester, Sussex: Phillimore, 1986), p. 138; Edward Shorter, *A History of Psychiatry* (New York: John Wiley, 1997), p. 231; Edgar Jones, Shahina Rahman, and Robin Woolven, 'The Maudsley Hospital: Design and Strategic Direction, 1923-1939', *Medical History* **51** (July 2007), 357-78.

institutions could only admit certified patients, with the exception of the Maudsley and City of London, which secured statutory exemptions in the 1910 and 1920s. Even with the introduction of voluntary treatment after the Mental Treatment Act, 1930, authorities had to contend with large chronic populations, a legacy of older buildings, and the reluctance of patients to submit themselves for institutionalisation. Convalescent villas therefore provided a solution to a complex of interrelated issues, comparable to those Mathew Thomson has identified in the early twentieth-century colony solution for mental defectives.⁷ They allowed those who managed and regulated mental hospitals to increase beds, focus on the most curable, and crucially, claim interwar mental hospitals offered a modern and progressive approach to mental treatment.

Nevertheless, it is significant that psychiatrists from the 1900s also began to take a more active part in the work of the Mental After-Care Association (MACA), in ways that corresponded with a broader concern with early treatment in this period. In this respect at least, it is possible to see a drift beyond the asylum, as Scull and Shorter have claimed. An expansion of voluntary cottage home care to those still the responsibility of asylums (1913), and those who had never entered an asylum (c.1917, 1924) expanded the concept of convalescence itself. Formerly restricted to those discharged 'recovered' from asylums, convalescence as a practice of organised care was from the 1910 and 1920s extended to cover borderline mental illness in the community, and a period of supervision on trial previously left to families in the private sphere. The removal of such patients

⁷ Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c. 1870-1959* (Oxford: Oxford University Press, 1998), pp. 114-20.

both from the asylum and from the community perhaps reflects a heightened concern amongst psychiatrists and voluntary workers at the double danger institutions and the family home posed to recovery. This conclusion corresponds with other research into suburban neurosis, psychiatric social work, and industrial health, which has collectively substantiated Scull's contention that interwar psychiatry 'ventured forth to capture an ever wider sphere for its ministrations and interventions'.⁸ In this respect, public mental hospital superintendents' involvement in and support for the MACA suggests convalescence may have offered one way for these professionals to escape the legalistic strictures of asylum practice. Akinobu Takabayashi has claimed it was mainly private asylum superintendents who sought to focus on early treatment in the early twentieth century, as a means to retain therapeutic credibility amongst their clients.⁹ It appears, however, that many public asylum superintendents participated in the development of voluntary convalescent services over the same period, in ways that suggest they too sought participation in community-based care beyond the asylum.

⁸ Andrew Scull, 'Psychiatry and Social Control in the Nineteenth and Twentieth Centuries', *Social History of Medicine* 2 (June 1991), p. 164; Kathleen W. Jones, "'Mother Made Me Do It': Mother-Blaming and the Women of Child Guidance', in Molly Ladd-Taylor and Lauri Umansky (eds), *"Bad" Mothers: The Politics of Blame in Twentieth-Century America* (London and New York: New York University Press, 1998), p. 101; John Stewart, "'I Thought You Would Want to Come and See His Home": Child Guidance and Psychiatric Social Work in Inter-War Britain', in Mark Jackson (ed.), *Health and the Modern Home* (Abingdon, Oxon; and New York: Routledge, 2007), pp. 111, 118-9; Rhodri Hayward, 'Housewives, Neuroses, and the Domestic Environment in Britain, 1945-70', in Jackson (ed.), *Health and the Modern Home*, pp. 43, 46-7.

⁸ Scull, 'Psychiatry and Social Control', p. 164; A.J. Mclvor, 'Manual Work, Technology, and Industrial Health, 1918-39', *Medical History* 31 (April 1987), 160-89; Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (London and New York: Routledge, 1990), pp. 9, 65-74; Vicky Long and Hilary Marland, 'From Danger and Motherhood to Health and Beauty: Health Advice for the Factory Girl in Early Twentieth-Century Britain', *Twentieth Century British History* 20:3 (2009), pp. 459-61.

⁹ Akinobu Takabayashi, 'The Political Economics of English Psychiatry in the Early Twentieth Century' (unpublished PhD thesis, University College London, 2008).

At the same time, it also seems that the development of community-based approaches to convalescence should be interpreted as related to, and not separate from, the development of convalescent villas within interwar mental hospitals. Indeed, Chapter Three has suggested that the relationship between the LCC and the MACA was central to the development of a more integrated approach to convalescence, which combined convalescent villas within mental hospitals, and cottage homes in the community. So too, the engagement of psychiatrists in the MACA's work, most notably from the 1900s, supports Mathew Thomson's proposition that the residential treatment in the 1920s may have formed part of a 'hidden history' of psychiatric care in the community.¹⁰ Whilst Thomson and Louise Westwood have claimed that the most innovative approaches to psychiatric treatment and care came from beyond the asylum, often in the voluntary sector, it appears to some extent that these two spheres overlapped.¹¹ As Vicky Long has argued, the MACA and publications such as the *JMS* offered a 'sub-public sphere' for the contestation of different notions of convalescence.¹² Prominent superintendents such as J.R. Lord, Hubert Bond and Henry Rayner are amongst those who participated in the development of new approaches to convalescence across both the voluntary and mental hospital sectors. The reference to these men in both Chapters Two and Three

¹⁰ Mathew Thomson, 'Community Care and the Control of Mental Defectives in Inter-War Britain', in Peregrine Horden and Richard Smith (eds), *The Locus of Care: Families, Institutions and the Provision of Welfare since Antiquity* (London and New York: Routledge, 1998), pp. 211-12.

¹¹ Louise Westwood, 'Avoiding the Asylum: Pioneering Work in Mental Health Care, 1890-1939' (unpublished PhD thesis: University of Sussex, 1999), p. 4; Mathew Thomson, 'Constituting Citizenship: Mental Deficiency, Mental Health and Human Rights in Interwar Britain', in Christopher Lawrence and Anna K. Mayer (eds), *Regenerating England: Science, Medicine and Culture in Inter-War England* (Amsterdam and Atlanta, GA: Rodopi, 2000), p. 241.

¹² Long, 'Public Representations of Mental Illness'.

provide an indication that to some extent at least, voluntary convalescence in the community was closely bound up with convalescence in the mental hospital.

Convalescent villas and cottage homes reinforced the concept of convalescence itself, making it more visible, and providing a focal point for debate on the needs of patients during recovery. Descriptions of these buildings in the interwar period, suggests that the sociability Chris Philo has speculated underpinned mental convalescence in the nineteenth century may have continued to be important into the twentieth.¹³ Rest and supervision in a familial and familiarly homely environment seems to have been most important to mental convalescence, whether inside or outside the mental hospital. The emphasis placed on the small scale, secluded location, and internal domestic arrangements of these homes all reflected their intended function as ordinary and home-like retreats, which prepared patients for a return to their own homes, but within a managed and supervised environment. As in the nineteenth century, such homely attributes continued to be defined in opposition to the barrack-like asylum, as temporary and precautionary alternatives to discharge into the community itself. There is some suggestion that mental convalescence may have functioned to instil 'bourgeois rationality' into patients, as Vicky Long has claimed. This seems to have centred primarily on the creation of a normative family environment under the efficient, cheerful, and hospitable stewardship of cottage home matrons. A desire to make convalescents productive may

¹³ Chris Philo, *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter, Ceredigion, and New York: Edwin Mellen Press, 2004), p. 612.

also have been part of this bourgeois rationality, as Long has claimed. This is perhaps evidenced in the preparations the MACA and matrons made to ready patients for work, and from the late 1930s, proactively find vocational employment.¹⁴ Yet the MACA focused most heavily on rest, change and good diet for most of the period. It seems, therefore, interwar convalescence derived from a much older tradition of holistic therapy traceable to late eighteenth-century moral therapy at the York Retreat.

Although patients drew attention to diet and fresh air, these seem less important considerations in the provision of mental convalescence than to the general convalescent homes Jenny Cronin has examined in the context of interwar Scotland.¹⁵ Rather, the justifications given for mental hospital- and community-based convalescence suggests mental convalescence was directed at a double-danger particular to psychiatric recovery. This centred on the risk to recovery posed on one hand by those insensible to their madness within asylums, and on the other by a sane but often insensitive and difficult world outside. Separation and seclusion formed the basis of such 'half-way homes' from the nineteenth century onwards, in the writing of those such as W.A.F. Browne and Henry Hawkins. Twentieth-century proponents of the convalescent villa and cottage home, however, articulated this need for seclusion as part of a discourse of early treatment, which proposed that convalescence should commence sooner, whether as an adjunct to admission hospitals or through voluntary 'early care' convalescence. As such, these apparently old-fashioned buildings assumed

¹⁴ Long, 'Public Representations of Mental Illness', p. 191.

¹⁵ Jenny Cronin, 'The Origins and Development of Scottish Convalescent Homes, c.1860-1939' (unpublished PhD thesis, University of Glasgow, 2003), pp. 186-9.

a key place in psychiatric interventions into the family home as a site of mental illness, as well as supporting mental hospitals' claims to a more preventive role in psychiatric treatment. Indeed, while the convalescent home mimicked the normalcy of the private home, it also created an artificial environment that delayed their return to independent lives in the wider community. Implicitly, therefore, convalescence served to pathologise the home and the workplace, and tacitly critiqued the ability of those in wider society to sustain recovery. Although cottage homes introduced convalescents into private homes, these nevertheless functioned as an extension of skilled psychiatric care.

What it meant to be 'convalescent', however, depended only partially on the buildings set aside for patients, or the functions those who planned them intended they should serve. Patients, families and friends also critically appraised organised convalescence. Each of these patients is likely to have had what Catharine Coleborne has termed an 'emotional response' to their stay, and these are to some extent legible in the writing and actions of cottage home patients.¹⁶ Through escapes and suicides, residents in voluntary cottage homes challenged their belonging as 'convalescents'. Still others sought to leave early, or conversely to stay or return. More frequently, those who described their stay favoured other terms such as 'holiday' over the term convalescence. This connection between convalescence and holidays in the interwar period corresponds with Jenny Cronin's findings, and suggests convalescence may have possessed wider social meaning. Adverts for tonics, and newspaper articles that described entire countries in

¹⁶ Catharine Coleborne, 'Families, Insanity, and the Psychiatric Institution in Australia and New Zealand, 1860-1914', *Health and History* 11:1 (2009), p. 72.

convalescence, indicate that the term enjoyed wider social usage beyond the formal confinements of the convalescent home. Cronin has suggested that in the sphere of general convalescence, it was providers who helped forge a connection between convalescence and vacations, through admission policies extended in the interwar years to those on 'recuperative holidays'.¹⁷ Patient responses to their treatment, however, suggest that patients may also have independently held their own view that their stay represented a holiday. As such, it provides an example of Ian Hacking's claim that classifications such as convalescence are 'interactive', and exist within a wider social matrix in which the classified patient, as well as the classifying service provider, makes sense of the condition.¹⁸

Just as historians have suggested families and patients may have exploited institutional treatment within the asylum for temporary periods, Chapter Four has also suggested that they may have used temporary convalescence as a bridging period in times of need.¹⁹ Rate-assisted patients had fewer options for treatment, compared with the private patients, and voluntary convalescence is therefore likely to have provided a comparable break to the private nursing homes and sanatoria available to wealthier clients.²⁰ Some convalescents evidently felt close enough to matrons to voluntarily return after their discharge, or return for further treatment, even

¹⁷ Cronin, 'Scottish Convalescent Homes', pp. 152-5.

¹⁸ Ian Hacking, *The Social Construction of What?* (London; and Cambridge, MA: Harvard University Press, 1999), pp. 31-4.

¹⁹ Suzuki, *Madness at Home*, p. 64; David Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine* **10** (March 1997), pp. 150-1; Mary Fisher, "'Getting Out of the Asylum": Discharge and Decarceration Issues in Asylum History' (unpublished PhD thesis, University of East Anglia, 2003), pp. 137, 224-6.

²⁰ Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London and New York: Routledge, 1992), pp. 214-5.

whilst other patients and their families rejected the care offered to them. Patients to some extent acted as stakeholders in the MACA's homes in particular, where they contributed financially through the indirect receipts of mental hospital patients' sales of work, and direct retrospective contributions for personal care they received. The convalescent home has provided a convenient focus for my thesis, as a central hub for organised convalescence in relation to the interwar public mental hospital. Patients themselves to some extent contributed to the continuance of these homes, not only through repayments for the cost of their care, but through their complicity in treatment, and occasional criticism of cottage home conditions. Perhaps more importantly, patients held their own personal perspectives on their treatment and made sense of the convalescence they received within their own personal narratives of mental illness and health.

Future research might usefully extend beyond these homes, and consider how patients may have viewed their recoveries in the community. In particular, this thesis has pointed to the need for more work into the impact of psychiatric social work on ideas of recovery, and the relative usage and meaning applied to alternate terms, such as 'adjustment' and 'rehabilitation'. The expansion of industrial psychology in the 1920s, and child guidance in the 1930s, provide two prominent examples of how the management of maladjustment may have relocated to the community, and therefore beyond the convalescent home. The respective work of Nikolas Rose and John Stewart on these developments has suggested that a more community-based approach to recovery emerged between the wars, based upon a claim

to a more scientific approach to treatment.²¹ The proliferation of new sites of treatment and research for psychiatric social work in the 1930s in clinics and mental hospitals followed the creation of separate rehabilitation centres for ex-servicemen after World War One. It is possible, therefore, that the interwar period originated an alternative approach to recovery, which took the patient out of the temporary seclusion of the convalescent home, and sought instead to resolve psychiatric disorders in social contexts. These efforts centred upon the adaptation of the individual to their immediate social environment, and resolution of a mismatch between individual psychology and the psychological effects of domestic or occupational environments. A drift towards more socially-situated notions of recovery are evident in the MACA's activities with early care convalescents from the 1920s and vocational social work from the 1930s. Further work is needed, however, on the origins and meanings of alternatives to convalescence outside the convalescent homes that have provided the primary focus of this thesis.

As a practice convalescence depended upon the willing participation of a variety of bodies and individuals. The LCC appears to have performed a central role in the development of both new asylum and voluntary approaches to convalescence. Yet as Chapter Two has explored, it was the BoC who most vigorously promoted the potential advantages of the mental hospital convalescent villa. How far they were built depended significantly on the provincial decisions of local authorities and the local availability of voluntary aftercare branches. In some areas, such as Bristol and Brighton,

²¹ Rose, *Governing the Soul*, pp. 65-74; John Stewart 'The Scientific Claims of British Child Guidance, 1918-45', *British Journal for the History of Science* **43** (September 2009), pp. 413-5.

novel local approaches to convalescence were developed that placed patients entirely outside the asylum. Elsewhere, overcrowding proved important to the implementation of the sort of convalescent villas the BoC sanctioned. Innovation often appears to have taken place out of necessity at those asylums such as the LCC's that had the greatest need for new beds. It is instructive in this regard that the BoC repeatedly sought to persuade local authorities to build convalescent villas through an appeal to the increased accommodation that these would provide. Such imperatives, and the relative proximity of the MACA's homes, seem to have lain behind the particularly close working relationship between this charity and the LCC in the interwar period. Cronin has suggested that the most successful general convalescent homes were those who attracted support through cooperatives and community support, whilst those who relied on local authorities tended to decline.²² Steven Cherry has also argued that patients themselves may have underwritten a large part of their care in this period.²³ In contrast, voluntary cottage homes flourished precisely through an increasing reliance on local authorities for maintenance payments, most notably the LCC.

A variety of agencies contributed to making mental convalescence from English public mental hospitals a more systematically organised and standardised procedure, albeit subject to significant local variation. An invigorated MACA, successive official inquiries, a proactive central government department, and the participation of patients and families all contributed to the interpretation and development of mental convalescence

²² Cronin, 'Scottish Convalescent Homes', pp. 123-7.

²³ Steven Cherry, 'Before the National Health Service: Financing the Voluntary Hospitals, 1900-1939', *Economic History Review* **50** (May 1997) pp. 315, 322.

between 1919 and 1939. Their interpretations indicate the range of managerial, medical and social values that might be placed on recovery, which potentially continue to inform decisions over care-giving to those in recovery today. Pressures on budgets and beds, professional measures of performance indicated by recoveries, and the use patients make of available facilities to provide respite and rest all remain potentially relevant concerns. In the interwar period, those who provided and managed convalescent homes claimed to address an old problem with renewed vigour. They claimed convalescence preserved health by keeping patients outside maddening asylums, yet also beyond a 'world of work and worry'. In turn, however, this thesis has indicated other concerns may have contributed to their expansion and use, in ways that suggest modern community care at least partly derived from the interests of the community and mental hospital profession, as well as of the recovering patient.

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Appendix 1

Admission Hospitals and Convalescent Villas across the London County Council's Mental Hospitals (excluding the Maudsley) before 1939.

Mental Hospital	Year Opened	Male Admission Hospital	Female Admission Hospital	Male Convalescent Villa (other information)	Female Convalescent Villa (other information)
Hanwell	1831	1931		<i>None</i>	<i>None</i>
Colney Hatch	1851	c.1924–6	By 1931	<i>None</i>	'Two villas' by 1931. Former isolation hospital had been intermittently used as a convalescent home, 1865–1914. Six new female villas added 1910.
Banstead	1877	c. 1933		c. 1933 (previously 'hospital... for parole patients')	By 1931 (previously Chaplain's house)
Cane Hill	1883	<i>None</i>	<i>None</i>	By 1931 Portnalls House, opened 1921, was being used for convalescents and quiet chronic cases by 1936)	By 1931 (Garden House in use for female convalescents, 1936)
Claybury	1893	1937	1928	1937	1928
Bexley	1898	1905	1898	c.1906 (isolation hospital at this date accommodated male convalescents)	c.1903 (previously Superintendent's house)
Horton	1902	1902	1902	<i>None</i> (isolation hospital temporarily used c. 1907–9)	1907 (formerly Steward's house) 1923 (Villa I adapted for convalescents)
Ewell	1903	1936	By 1931	1936	By 1931
Long Grove	1907	1907	1907	1907	1907
West Park	1924	1924		1924	1924

Source: LMA, LCC, Presented Papers, July 1931; Lunacy Commission/ BoC, Annual Reports

Appendix 2
Distribution of the Mental After-Care Association's Sources of Income, 1913–17, 1925–29, 1931–39

Year	Subscriptions/ Donations	Contributions on Account of Services Rendered	Other	Queen Adelaide Fund	Queen Adelaide Fund / Grants for Cases on Trial	King Edward's Hospital Fund for London	TOTAL
1913	£838.33 (34.8%) £1,479.90		£1,511.67 (62.7%) £2,668.56 in 1939 values (decimal equivalent)	£60.68 (2.5%) £107.11 in 1939 values (decimal equivalent)			£2,410.68 £4,255.58 in 1939 values (decimal equivalent)
1914	£719.41 (57.6%) £1,269.97		£408.15 (32.7%) £720.50	£120.75 (9.8%) £213.16			£1,248.31 £2,203.64
1915	£771.33 (57.1%) £1,213.09		£416.83 (30.9%) £655.55		£162.46 (12.0%) £264.94		£1,350.62 £2,124.15
1916	£696.51 (42.1%) £926.89		£653.28 (39.5%) £869.39		£305.20 (18.4%) £406.15		£1,654.99 £2,202.40
1917	£874.51 (49.0%) £928.16		£584.25 (31.6%) £620.09		£346.25 (19.4%) £367.49		£1,785.01 £1,894.51
// 1925	£2,683.12 (36.1%) £2,495.59	'Public Authorities' £1,236.07 (16.7%) £1,149.67	£2,512.81 (33.8%) £2,337.18	£841.83 (11.3%) £782.99		£150.00 (2.0%) £139.51	£7,423.83 £6,904.96
1926	£2,501.00 (33.1%) £2,338.77	'Public Authorities' £1,663.01 (22.0%) £1,555.13	£2,425.22 (32.1%) £2,267.90	£823.74 (10.9%) £770.30		£150.00 (2.0%) £140.27	£7,562.97 £7,072.39
1927	£2,005.71 (24.7%) £1,927.71	'Public Authorities' £1,370.07 (16.9%)	£3,177.16 (39.1%) £3,053.60	£904.97 (11.1%) £869.77		£150.00 (1.8%) £144.16	£8,119.20 £7,803.45

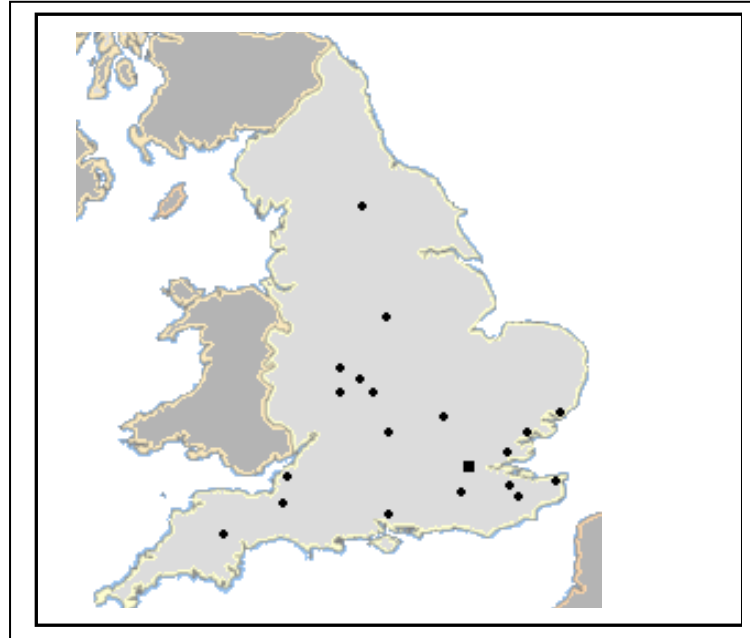
		£1,316.78					
1928	£2,517.00 (28.1%) £2,419.11	'Public Authorities' £1,539.75 (17.2%) £1,479.87	£3,727.33 (41.6%) £3,582.37	£1,053.55 (11.8%) £1,012.57		£125.00 (1.4%) £120.13	£8,962.63 £8,614.08
1929	£3,157.56 (30.4%) £3,068.86	'Public Authorities' £2,618.90 £2,545.33	£3,160.94 (30.4%) £3,072.14	£1,322.09 (12.7%) £1,287.95		£125.00 (1.2%) £121.48	£10,384.49 £10,092.79
// 1931	£3,469.53 (27.9%) £3,615.83	£7,279.37 (58.6%) £7,586.33	£1,427.41 (11.5%) ¹¹⁴⁶ £1,487.60			£250.00 (2.0%) £260.54	£12,426.31 £19,950.31
1932	£3,247.48 (29.9%) £3,467.98	£7,046.43 (64.8%) £7,524.89	£324.88 (3.0%) £346.93			£250.00 (2.3%) £266.97	£10,868.79 £11,606.79
1933	£3,409.00 (28.9%) £3,732.63	£7,789.87 (66.0%) £8,529.41	£348.12 (3.0%) £381.16			£250.00 (2.1%) £273.73	£11,796.99 £12,916.95
1934	£2,718.83 (19.1%) £2,976.94	£10,909.25 (76.5%) £11,944.93	£384.19 (2.7%) £420.66			£250.00 (1.8%) £273.73	£14,262.27 £15,616.28
1935	£2,755.93 (15.5%) £2,998.59	£13,114.00 (73.9%) £14,359	£1,573.20 (8.9%) £1,711.72			£300.00 (1.7%) £348.17	£17,743.13 £19,305
1936	£2,859.41 (14.6%) £3,091.73	£14,571.10 (74.6%) £15,755	£1,800.57 (9.2%) £1,946.86			£300.00 (1.5%) £324.37	£19,531.08 £21,117.98

1937	£2,969.44 (15.1%) £3,094.65	£15,712.18 (80.1%) £16,374.74	£608.66 (3.1%) £634.32			£320.00 (1.6%) £333.49	£19,610.28 £20,437.21
1938	£2,227.93 (9.9%) £2,293.23	£19,266.23 (85.4%) £19,939.62	£725.23 (3.2%) £746.81			£330.00 (1.5%) £339.82	£22,549.39 £23,220.50
1939	£2,240.33 (8.6%)	£22,220.35 (84.8%)	£1,336.15 (5.1%)			£400.00 (1.5%)	£26,196.83

See also Figure 15.

Appendix 3

Distribution of Branches of the MACA across England, 1904–25. This provides an impression of the concentration of new branches in the south-east and midlands, although some of these appear to be short-lived, and this only shows those listed in annual reports.



Source: WLHUM, MACA, SA/BAC/B.1, Annual Reports, 1904–25