

**“WHAT DID THEY DO ALL DAY?” PATIENT WORK,
PSYCHIATRY AND SOCIETY IN FRANCE AND ENGLAND,
c.1918-1939**

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Abstract

This study compares patient occupation in English and French mental hospitals between 1918 and 1939, a period that witnessed the transfer of new ideas concerning occupational therapy from Germany and the USA. Examining the different socio-economic, cultural and medical influences on patient occupation in both metropolitan and provincial mental hospitals, the study assesses the varied rationale for its prescription by psychiatrists. It is argued that the different professional trajectories of French and English psychiatry led to different responses to the new theories of occupation. It is also argued that for the new methods of occupational therapy to be successfully introduced, certain conditions had to be met. These conditions, which included medical directorship of institutions, skilled nursing, a focus on active treatment rather than custodial care, favourable staff to patient ratios, adequate financial resources, and freedom from overcrowding, were met differently in France and England.

The comparative methodology utilised in this study has suggested that French psychiatry's close alliance with the more prestigious discipline of neurology led to an interpretation of mental disorder that did not embrace psychological methods of treatment, such as occupation, for acutely ill patients. In France, occupation in the form of work around the hospital remained the preserve of the chronically ill and convalescent patients, and continued to be regarded as an essential means of offsetting institutional running costs, as it had been before World War I. In England, on the other hand, occupational therapy was welcomed as an effective means of re-educating the mentally ill and of engaging patients at all stages of their illness.

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Abbreviations

AD	Asylum Director, who shared responsibility for management of French asylums with the CMO(s).
ADLS	Asile de la Sarthe
ADP	Archives de Paris – archives for the Asile Clinique, Ste Anne’s and the SLPM
ADS	Archives de la Sarthe – archives for the ADLS
AOT	American-style OT
APAS	Asiles Publiques des Aliénés de la Seine
AU	Author Unknown – used when a journal article is unattributed
BMM	Bethlem Museum of the Mind – archives for Bethlem and the Maudsley hospitals
BoC	Board of Control – the body responsible for overseeing the provision of care for the mentally disordered in England and Wales; the BoC reported to the Ministry of Health from 1919
BRH	Bethlem Royal Hospital
CDS	Commission de Surveillance
CGS	Conseil Général de la Seine
CMO	Chief Medical Officer (or <i>Médecin en Chef</i>) (French mental hospitals)
ECT	Electro-Convulsive Therapy
GPI	General paralysis of the insane
HRH	Henri Rousselle Hospital – part of the SLPM
ICT	Insulin Coma Therapy
LARs	Littlemore Annual Reports – these combined reports from the Visiting Committee, the MS and the BoC
MAT	“More Active Therapy”- Hermann Simon’s method of OT
MHR	Maudsley Hospital Report
MPA	Medico-Psychological Society
MS	Medical Superintendent (English mental hospitals)
OHA	Oxfordshire Health Archives – archives for the Littlemore hospital
OT	Occupational Therapy
PDS	Préfecture de la Seine
PS	Physician Superintendent (Bethlem only)
RMPA	Royal Medico-Psychological Society (the society became “Royal” in 1926)
SLPM	Service Libre de Prophylaxie Mentale – the new “open” service established by Édouard Toulouse in Paris

Chapter 1:

Introduction

1.1 The Topic of This Study

This thesis compares how and why patient occupation¹ developed in France and England between 1918 and 1939. It examines the varied rationale for patient work in metropolitan and provincial institutions in both countries and analyses the socio-economic, political and medical influences upon its prescription by psychiatrists. Differences in attitudes towards occupation held by French and English psychiatrists are linked to the divergent trajectories and stages of professionalisation within French and English psychiatry and mental nursing; to different conceptions regarding the origin and nature of mental disorder; to the different economic circumstances of each country; and to the different management structures within French and English institutions. These differences led to new approaches to therapeutic occupation being adopted in England, while in France, patient work did not evolve in the same way.

1.2 The Original Contribution to Knowledge

Patient work has rarely been subject to systematic historical analysis. The interwar period has received even less attention, particularly in France, where interwar psychiatry is often dismissed by historians as “immobile” or “frozen”, as Isabelle von Buelzingsloewen observes.² This study challenges this notion, demonstrating that, while by no means nationwide, new approaches to psychiatric care were being developed in Paris during the interwar period, as indicated by changes to the way patient occupation was organised. To date there is no comparative study of patient work in France and England, a lacuna filled by the present study, which is based on original archival research in both countries. The

¹ In this thesis “occupation” is interpreted as a generic term for patient work (therapeutic or otherwise) and occupational therapy. “Patient work” refers to the tasks carried out by patients to assist the smooth-running of the institution, which may or may not have fulfilled a therapeutic function. “Occupational therapy” (or OT) refers to the new methods of therapeutic occupation developed in the early twentieth century in Germany and the USA.

² Isabelle von Buelzingsloewen, “Réalité Et Perspectives De La Médicalisation De La Folie Dans La France De L'entre-Deux-Guerres,” *Genèses* 1, no. 82 (2011): 54.

present study situates the prescription of patient work and occupational therapy in the context of the professionalisation of French and English psychiatry. It is argued that for occupational therapy (or OT), to be incorporated as a medicalised form of active treatment, certain conditions had to be met. These conditions included the specialist training of psychiatrists and mental nurses; the establishment of psychiatry as an independent discipline; an ideological shift from an organicist perspective of mental disorder to one that embraced a more holistic approach;³ a focus on active treatment rather than custodial care; the establishment of medical direction of the institution; and the existence of propitious material conditions, such as freedom from overcrowding. The introduction of OT was thus both dependent upon, and an indicator of the achievement of, certain standards of care and professionalisation. Patient occupation has not been examined from this perspective before.

1.3 The Post-War Context

World War I was a watershed event that divided the old world from the new politically, economically, ideologically, and medically. The mass slaughter of the war took place on an unprecedented scale. Approximately ten million people across the world lost their lives and every combatant country emerged from the war with a significant gender imbalance.⁴ The war and subsequent peace treaties caused massive migration; in 1926, there were 9.5 million refugees across Europe. The dynastic empires of Germany, Russia and Austria-Hungary were eliminated by the war.⁵ Economic crises rocked already unstable political regimes. The immediate legacy of World War I comprised “upheaval, fragmentation and insecurity”.⁶ The sense of acute crisis caused by the war was exacerbated by the Russian

³ An organicist perspective is one that situates the origin of mental disorder in the organs of the body; psychiatrists adopting an organicist perspective believed that all mental disorders had an organic or physiological basis, i.e. they were due to structural brain changes or biochemical disturbances of the nervous or glandular systems.

A holistic approach incorporates social and psychological factors as well as physiological factors; psychiatrists adopting a holistic approach considered the whole person (including life-style, diet, mental health, emotional state and physical condition) when treating mental disorder.

⁴ Pamela Pilbeam, "Social and Economic Developments in Europe, 1890-1939," in *Themes in Modern European History 1890-1939*, ed. Nicholas Atkin and Michael Biddiss (London and New York: Routledge, 2009), 53.

⁵ Ibid.

⁶ Julian Jackson, *Europe 1900-1945* (Oxford: Oxford University Press, 2002), 8.

Revolution and the influenza pandemic that killed an estimated 100 million people worldwide.⁷

As the French poet Paul Valéry put it in 1922, “almost all the affairs of men remain in a terrible uncertainty”.⁸ Of all the aspects of life that had been injured by the war, Valéry claimed the mind was the worst affected: “The mind has indeed been cruelly wounded ... It doubts itself profoundly”.⁹ Individuals struggling to make sense of the post-war world experienced feelings of dislocation, anomy and spiritual disorientation.¹⁰ Pre-war values and beliefs were swept away, as the war “ripped up the historical fabric and cut everyone off from the past suddenly and irretrievably”.¹¹ There was a widespread sense that the ideals of “western civilisation”, taken for granted before 1914, confronted “a critical, perhaps even fatal, turning point”.¹² Some historians emphasise a post-war “craving for newness” and the prevalence of a cynicism about convention amongst the post-war generation, while others warn against overexaggerating the rupture between old and new, claiming that traditional values co-existed with modernist views after the war.¹³ This raises the question of whether the war inspired a renewed energy for reform in the care of the mentally ill, particularly in the light of so many devastating cases of mental illness caused by the conflict, and how that may have affected asylum regimes and work programmes, or whether traditional modes of practice pertained in France and England.

1.4 A brief history of patient work

Belief in the therapeutic properties of work for the mentally ill has a long history. Galen proclaimed as early as c. ACE 170 that work was “nature’s physician” and early modern physicians emphasised the importance of balancing the six non-naturals in order to remain healthy in mind and body.¹⁴ In the modern era, the recognised starting point for a history of

⁷ Roger Griffin, *Modernism and Fascism: The Sense of a Beginning under Mussolini and Hitler* (Basingstoke and New York: Palgrave Macmillan, 2007), 163.

⁸ Modris Eksteins, *Rites of Spring: The Great War and the Birth of the Modern Age* (Boston and New York: Houghton Mifflin, 1989), 257.

⁹ Ibid.

¹⁰ Griffin, *Modernism and Fascism*, 162-3.

¹¹ Cited in *ibid.*, 161.

¹² R.J. Overy, *The Inter-War Crisis 1919-1939*, Second ed. (Harlow: Pearson Education, 2007), 38.

¹³ Eksteins, *Rites of Spring*, 258; J. M. Winter, *Sites of Memory, Sites of Mourning: The Great War in European Cultural History* (Cambridge: Cambridge University Press, 2014), 115.

¹⁴ Louise Hill Curth, “Lessons from the Past: Preventative Medicine in Early Modern England,” *Medical Humanities* 29, no. 1 (2003): 16-20. The six non-naturals included air, food and drink, exercise and rest, sleep

patient work is the late-eighteenth century when asylum reforms, originating in the humanitarian ideology of the Enlightenment, resulted in the emergence of moral therapy.¹⁵ The theories of moral therapy, developed independently in France and England by Philippe Pinel (1745-1826) in France and William Tuke (1732-1822) in England, held that asylum patients should be provided with “psychosocial” treatment including work appropriate to the individual’s aptitudes and abilities, and as similar as possible to their previous occupation.¹⁶ The principles of moral therapy became the ideal to which most asylum superintendents aspired, and work programmes for patients flourished in the mid-nineteenth century.

Towards the end of the nineteenth century, however, as an organicist view of mental disorder, based on Bénédictine-Auguste Morel’s (1809-73) theory of hereditary degeneration (introduced in 1857), gained widespread support amongst French and British psychiatrists, the principles of moral therapy, which were associated with a psychical (or psychological) interpretation of mental disorder, were rejected. Patient work in the asylum kitchens, laundries and farms continued, free of its original context. The contribution to institutional running costs made by patient labour began to take precedence over the value of work as a therapy. By the early twentieth century, when most public asylums were overcrowded and underfunded, patient work became increasingly geared towards institutional profit and was based upon an intolerance of “idleness”.¹⁷ The need to rehabilitate shell-shocked soldiers during and after World War I led to new approaches in psychiatric treatments, including the use of occupation by British and American military physicians. After the war, amid changing attitudes towards poverty and welfare and the emergence of new theories regarding therapeutic occupation, the rationale for patient work changed again as occupation

and waking, repletion and evacuation, and the passions and emotions. Exercise might include walking, dancing, sport or manual labour.

¹⁵ Jennifer Laws, "Crackpots and Basket-Cases: A History of Therapeutic Work and Occupation," *History of the Human Sciences* no. 24 (2011): 65-81.

¹⁶ Ibid.

¹⁷ Aude Fauvel, "A World-Famous Lunatic: 'The Sellière Affair' (1887-1889) and the Circulation of Anti-Alienists' Views in the Nineteenth Century," in *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, C.1800-2000.*, ed. Waltraud Ernst and Thomas Mueller (Cambridge: Cambridge Scholars Publishing, 2010), 200-28.

appeared to regain its reputation as an essential aspect of good mental and physical health.¹⁸

This study addresses how such attitudinal changes were incorporated into French and English mental hospital practice, thus highlighting the way in which society and psychiatry are intrinsically linked and how work and activity in mental institutions have evolved over time in response to wider social, institutional and medical contexts. Specifically, the study examines why patients were still being given work to do in the 1920s and 1930s, following the seismic economic, social, cultural and medical changes brought about by World War I. Was work still regarded as therapeutic, independent of its original context? Or were there alternative rationales that might explain why patients worked? Was patient work affected by the emergence of new medical treatments for mental disorder?

1.5 The Legal Framework within which Mental Hospitals operated in France and England

The legal institution of a national, state-funded system of care for the mentally disordered poor began in the early nineteenth century in both England and France. Patient work and occupation were provided in the context of the legal frameworks within which French and English asylums, the approved locus of care for the mentally disordered, were established. In England, legislation was introduced piecemeal throughout the nineteenth century. The County Asylums Act of 1808, the result of calls for lunacy reform by evangelical humanists and utilitarians, empowered (but did not require) local authorities to raise a county rate for the purpose of building an asylum for the county. The institutions were to be built in an “airy and healthy situation” with a good supply of water.¹⁹ There were to be separate wards for men and women, and for convalescent and incurable patients, together with day rooms and airing grounds for different classes of patient. Although the asylums were to provide “constant” access to “medical assistance”, there were no regulations regarding treatment.²⁰

An English Code of Practice drawn up in 1827 set out the standards of care that asylums should aim to provide, including the application of moral therapy, and standards referring to

¹⁸ Waltraud Ernst, ed. *Work, Psychiatry and Society, C.1750-2015* (Manchester: Manchester University Press, 2016).

¹⁹ Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s*, Second ed. (London: Athlone, 1993), 37.

²⁰ Ibid.

food, cleanliness, exercise and occupation. On the latter, the Code advocated manual labour and activities designed to “engage the attention to external objects” such as drawing, painting or gardening. Amusements, such as music or looking after animals, were to be provided, as were intellectual pursuits for “patients of a superior description”.²¹ Whilst there were no means of enforcing the recommendations outlined in the Code, the principle of inspecting asylums was introduced by the County Asylums Act of 1828. This Act stipulated that asylums with more than 100 patients should have a resident medical officer and that proprietors should keep detailed records that could be inspected. The body of inspectors became known as the Commissioners in Lunacy according to the terms of the Lunacy Act of 1845 which made it a requirement that every county provided an asylum.²² The Lunacy Commission (1845-1913) and its successor, the Board of Control (1913-1959) were responsible for issuing directives concerning the internal regulation of institutions, including the treatment of patients and the protection of a patient’s civil rights.²³

In terms of admission, before 1819 in England, those who were deemed “dangerous to be at large” could be sent to the county asylum by the parish overseer; in 1819, this power was also granted to local magistrates.²⁴ During the latter half of the nineteenth century, cases of wrongful confinement, particularly in the private sector, caused public outrage and led to the establishment of a parliamentary select committee in 1877 to consider the operation of the lunacy laws.²⁵ The committee recommended that a detailed and lengthy enquiry take place before a patient was deprived of their liberty. Judicial certification eventually became law under the Lunacy Act of 1890.²⁶ This provided that patients could only be admitted to or detained in any institution for the mentally disordered if a “reception order” had been issued by a judicial authority, magistrate or county court judge and was supported by two medical certificates. Pauper patients could only be admitted on the order of a justice of the peace.²⁷ The delays to treatment caused by this ruling, and its potential threat to a patient’s

²¹ Ibid., 63.

²² Phil Fennell, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (London: Routledge, 1996), 15.

²³ Ibid., 6.

²⁴ Jones, *Asylums and After*, 37-8.

²⁵ Fennell, *Treatment without Consent*, 52.

²⁶ Ibid., 54.

²⁷ Ibid., 55.

chances of a cure, prompted calls for the introduction of “voluntary admission”, eventually granted in 1930 by the Mental Treatment Act.²⁸

By contrast, in France, legislation regarding care of the mentally disordered in asylums was delayed until 1838 due to successive political regime changes since 1789, a lack of finances and ongoing debates over whether asylums were to be considered as hospitals or as institutions of detention.²⁹ The campaign for reforming care of the insane was led by physician and former student of Philippe Pinel, Jean-Étienne Dominique Esquirol (1772-1840). His report of 1818 on the provisions made for the sick, the infirm, orphans, criminals and the insane concluded that of all the afflictions to which man was subject, mental disorder warranted the most urgent attention.³⁰ Guillaume Ferrus (1784-1861), another former pupil of Pinel, also campaigned for reform. His publication of 1834 highlighted the deplorable state of most institutions for the insane, and their uneven distribution across France.³¹ Spurred on by the legislative advances made in England, the French government passed the law of 30 June 1838 establishing the principal that each department should provide, or ensure access to, an asylum for the mentally disordered. Overseeing both public and private asylums was the responsibility of the local authorities. Admission became subject to strict regulations according to one of two modes: “*placement volontaire*” or “*placement d’office*”.³² According to the first, request for admission was made to the local prefect by the family of the individual and required a medical certificate from a doctor who was neither known to the family nor the asylum. The prefect then sought a further certificate from the asylum doctor, verifying the opinion of the doctor issuing the initial certificate, and permission from the judiciary, before committal could proceed. In the case of *placement d’office* the process of internment was initiated by the prefect due to the behaviour of a mentally disordered individual compromising public order or endangering others. After removal to an asylum, the individual would be subject to a period of

²⁸ The issue of delays to treatment caused by the certification process had been raised by Lord Shaftesbury, Chairman of the Lunacy Commission, who resigned over the matter in 1885.

²⁹ Jacques Postel and Claude Quézel, *Nouvelle Histoire De La Psychiatrie* (Paris: Dunod, 2012), 180.

³⁰ Claude Quézel, *Histoire De La Folie: De L'antiquité À Nos Jours* (Paris: Éditions Tallandier, 2009), 278.

³¹ *Ibid.*, 281.

³² *Ibid.*, 291.

observation by the asylum doctor. The latter produced a report for the prefect, who then decided whether the individual was to be retained in the asylum.³³

Further legislation instituted on 18 December 1838 regarding the functioning of asylums established the principle of the dual management of asylums, which was to be shared between an Asylum Director (AD) and a Chief Medical Officer (CMO). The CMO was responsible for all matters concerning the treatment of patients, while the AD took charge of administration.³⁴ Detailed regulations regarding how a model institution should function were the subject of the ministerial order of 20 March 1857. The order included instructions concerning the medical service, administration, the daily regime, dietary, and the provision of work and occupation for patients. The Minister responsible for the order declared that it completed the law of 1838 and was based on 18 years' experience of asylum management in France and on observation of the workings of asylums overseas.³⁵ This order, together with the original legislation of 1838, provided the legal framework for the management of asylums for the first half of the twentieth century. One of the main differences between the French and English legislation was the level of detail. The French *ordonnance* of 1857 specified in minute detail how asylums should be managed and how patients should be treated. The only area of ambiguity was the extent to which patient work was a medical or an administrative concern. This "grey area" is discussed in chapter four. In England, medical superintendents had more autonomy than their French counterparts and were less restricted by asylum legislation.

1.6 The Significance of Medical Superintendents, Chief Medical Officers and Nurses in French and English mental hospitals

The thesis explores the ways in which the level of authority and the therapeutic preferences, of the Medical Superintendent (MS) or Chief Medical Officer (CMO), together with the aptitudes and attitudes of the nursing staff and the level of training they received, impacted on the provision of occupation and recreational activities for patients. The significance of the role of the MS and CMO and that of the nursing staff are recurrent themes throughout the study. The professionalisation of both psychiatry and mental nursing

³³ Ibid.

³⁴ Ibid., 292-3.

³⁵ Ibid., 293.

varied between France and England, and between metropolitan and provincial areas, influencing the ability and inclination of medical and nursing staff to upgrade and supervise patient occupation. The incremental stages in the professionalisation of psychiatry and mental nursing are explored in relation to the provision of patient occupation in both city and rural institutions.

In France, the organicist stance of psychiatrists, which was linked to the close alliance forged between psychiatry and neurology and psychiatry's lack of professional independence, impeded the introduction of new methods of occupational therapy. This was compounded by the importance of existing methods of patient work to institutional budgets, a priority for the Asylum Director (AD) who shared responsibility for asylum management with the CMO. In England, the MS's authority within the asylum was unchallenged; it was up to the MS whether or not OT was introduced. OT was more likely to find favour amongst English psychiatrists because, after World War I, they upheld a more holistic interpretation of mental disorder than their French colleagues. Issues of professionalisation, and the therapeutic and financial priorities of MSs and CMOs are examined further in chapters three and four, with specific examples highlighted in chapters five and six.

Whilst the MS or CMO was responsible for prescribing occupation to patients (although this was tempered by the financial demands of the AD in France), it was the nursing staff who spent the most time with patients day-to-day and had to supervise their activities. The training, skill and commitment of the nurses were therefore crucial elements in the provision of patient occupation. These elements were linked to levels of professionalisation within mental nursing, another recurrent theme within this thesis. In England, the professionalisation of mental nursing occurred earlier and mental nursing was of a higher standard than in France. Mental nursing was unpopular as a profession in both countries, but particularly in France, where pay and conditions were poor and where there was an even greater stigma associated with mental nursing. These issues affected the standard of applicants to the profession, resulting in the recruitment of (secular) nurses who were often illiterate and lacking in commitment to their role. In England, training was offered nationwide, while in France, nurses in the metropolis received basic training but this was often absent in the provinces, where secular mental nurses were often recruited from outside nursing.

Nursing staff in French rural areas continued to be provided by religious orders until well into the twentieth century, despite the fact that France became a secular nation following the passage of the Separation Bill in 1905.³⁶ The latter ended the Napoleonic Concordat recognising the special relationship between the Catholic Church and French society. It meant that henceforth all French institutions, including schools and hospitals, were to be run on a secular basis. In the provinces, particularly in the west of the country where support for the Church remained strong, secularisation was patchy and occurred much more slowly than in the cities.³⁷ In these rural areas, nursing frequently adhered to religious principles, rather than those based on “modern republican medicine”.³⁸ At the ADLS, in the provincial department of La Sarthe, nursing on the women’s side had been provided by the religious order of the *Charité d’Evron* since 1870; secularisation did not occur until the 1960s.³⁹ The process of secularisation amongst asylum personnel happened much earlier in Paris and other large cities, where republican values predominated. In Paris, where asylum CMOs held staunchly republican views and pursued a reformist agenda, nursing had become secular in the 1870s. In contrast, psychiatrists of the Seine, where nursing was secular, believed that the employment of nuns as nurses impeded the introduction of modern methods. Religious discipline, they maintained, could create a “state within a state” and block doctors’ attempts at reform.⁴⁰ These issues, and how they impacted on the provision of patient occupation, are discussed in subsequent chapters.

1.7 Selection of Period, Locations and Institutions

As indicated above, patient work during the interwar period has not attracted significant scholarly attention and to date there is no comparative study of patient work in France and England during this period. This thesis seeks to address this lacuna. Studies of late-nineteenth-century psychiatry tend to end in 1914,⁴¹ before the outbreak of World War I,

³⁶ Roger Price, *A Concise History of France*, Second ed. (Cambridge: Cambridge University Press, 2005), 234.

³⁷ Hervé Guillemain, *Chronique De La Psychiatrie Ordinaire: Patients, Soignants Et Institutions En Sarthe Du 19e Au 21e Siècle* (Tours: Éditions de la Reinette, 2010), 41.

³⁸ “Le Soins En Psychiatrie Dans La France Des Années 1930.,” *Histoire, Médecine et Santé* Spring, no. 7 (2015): 81-2.

³⁹ Guillemain, *Chronique De La Psychiatrie Ordinaire*, 42.

⁴⁰ A. Porot, “L’assistance par le travail dans les Asiles Hollandais,” *L’Hygiène mentale*, no. 2 (1929): 251.

⁴¹ For example: Joseph Melling and Bill Forsythe, *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999); Jean-Christophe Coffin, *La Transmission De La Folie 1850-1914* (Paris: L'Harmattan, 2003).

while twentieth-century studies tend to focus on the introduction of pharmacological methods of treatment emerging in the 1950s, or on post-1959 British de-institutionalisation.⁴² France and England have been chosen partly because of the close alliance that existed between French and English psychiatrists (or alienists as they were called) during the nineteenth century. They followed professional developments in each other's countries; they were honorary members of each other's professional organisations and enjoyed a collaborative relationship.⁴³ France and England were also selected on the basis of the historical parallels in the development of their respective asylum systems and the contemporaneous emergence of theories regarding moral therapy by the English William Tuke and the French Philippe Pinel in the early nineteenth century.

Despite this professional collaboration and shared history, work therapy developed differently in each country after World War I, which provides a further incentive to investigate patient work in these two countries. The divergence was partly the result of the greater emphasis on neurology within French psychiatry's heritage, and the fact that psychiatry was yet to be established as an independent discipline, and partly due to English psychiatry's close association with American psychiatry initiated as a result of personal connections in the decade before World War I and exposure to American treatment methods during the conflict. After the war, British psychiatrists were more inclined to follow the lead of the USA, while (most) French psychiatrists were influenced by German approaches. This suggests that the war acted as a watershed in terms of transnational influence, an area that will be further investigated in chapter four.

Three institutions in France and three in England form the basis of this study; these include the London-based Bethlem Royal and Maudsley Hospitals, the Oxford County and City Mental Hospital at Littlemore (henceforth known as the Littlemore Hospital), the Parisian Asile Clinique and Henri Rousselle Hospital, both based within Ste Anne's, and the Asile de la

⁴² For example: John Welshman and Jan Walmsley, eds., *Community Care in Perspective: Care, Control and Citizenship* (Basingstoke and New York: Palgrave Macmillan, 2006).

⁴³ For example, Henri Colin visited Broadmoor Hospital in England prior to establishing the secure unit for the criminally insane at the Villejuif Asylum in 1910 and *The Journal of Mental Science* regularly featured reviews of French psychiatric texts and articles appearing in the French journals. Collaboration between France and Britain in relation to the pharmaceutical industry has been discussed by Viviane Quirke: Viviane Quirke, *Collaboration in the Pharmaceutical Industry: Changing Relationships in Britain and France, 1935-1965* (London and New York: Routledge, 2007).

Sarthe (the ADLS), Le Mans, in the rural department of La Sarthe. The four metropolitan institutions were selected on the basis of their specialising in acute cases of mental illness. This reflected the growing tendency, at least in city institutions, to treat curable and incurable cases separately.⁴⁴ The Henri Rousselle and Maudsley hospitals were similar in that they were both established (in 1922 and 1923 respectively) for the specific purpose of treating mild, incipient cases of mental disorder that did not warrant certification. They were the only public mental institutions in France and England where patients could be admitted voluntarily, before their symptoms became entrenched. Both institutions became important centres of psychiatric research. Bethlem, as a registered hospital, was able to accept voluntary patients. The hospital regulations stipulated that patients' conditions should be curable and the emphasis was on the early treatment of acute cases.⁴⁵ Under the National Health Service, the Bethlem and the Maudsley hospitals joined forces to become a Joint Hospital in 1948.⁴⁶ The Asile Clinique was transformed into a hospital for acute, curable patients in 1927, although admission remained subject to the law of 1838. Both the Littlemore Hospital and the ADLS were provincial institutions catering for a mixed clientele of curable and incurable cases. The choice of Bethlem (which did not admit paupers) and the ADLS (which admitted both pauper and private patients), facilitates a comparison of patient work carried out by middle-class and pauper patients in both England and France.

1.8 Sources

The archives consulted with regard to the six institutions included in this study were the Bethlem Museum of the Mind, London, for the Bethlem Royal and the Maudsley Hospitals; the Archives de Paris for the Asile Clinique and Henri Rousselle Hospital; the Oxfordshire Health Archives, Oxford, for the Littlemore Hospital; and the Archives Départementales de la Sarthe, Le Mans, for the Asile de La Sarthe (the ADLS). The documents examined included the hospital annual reports for the Bethlem, Maudsley and Littlemore Hospitals. In the case of the Maudsley, these reports were written solely by the Medical Superintendent, Edward Mapother, while the Bethlem and Littlemore Reports included reports from the Chairman of

⁴⁴ In France, rural colonies were established in the 1890s to treat incurable patients from the Seine department; while in England the Mental Deficiency Act of 1913 made separate provision for the intellectually impaired.

⁴⁵ Jonathan Andrews et al., *The History of Bethlem* (Abingdon and New York: Routledge, 1997), 649.

⁴⁶ *Ibid.*, 603.

the Visiting Committee, the Medical or Physician Superintendent, the Chaplain and the Board of Control inspectors. For the Asile Clinique, the annual reports to the Prefecture from the CMOs of the different divisions within the Asile Clinique (the Admissions Service, the Men's and Women's First and Second sections, and the Pharmacy) were consulted, together with the reports of the General Council of the Seine and the so-called Moral Reports (summaries of which were included in the General Council reports). The reports to the Prefecture contained the statistical information used to compile the tables (in the Appendices) regarding patient numbers, discharge rates, health and mental condition. The General Council reports were written from the perspective of the General Councillor, while the Moral Reports were written by the Asylum Director and contained the most detail regarding the number of patient workers and the type of work undertaken. The latter were only available for the period 1932-39. Annual reports were generated by the CMO (the Medical Report) and by the Asylum Director (the Director's Report) of the ADLS; it was interesting to find that there was more information about patient work in the Director's Report than the Medical Report. Appended to some, but not all, sets of asylum accounts were details of the work, and its allocated value, undertaken by patients. These reports were used to develop institutional micro-histories for the interwar period, along the lines outlined by Feldman and Lawrence.⁴⁷

In addition, the reports of the Board of Control (England) and the Commission de Surveillance (France), the bodies that oversaw the provision of institutional care for the mentally disordered, were consulted for their reports on individual institutions and to ascertain their stance (and therefore that of government) on patient work and occupation. In the case of the French Commission de Surveillance, the contents of the reports, which tended to focus on practical matters, such as sanitation and building works, were repeated in the General Council reports. The Board of Control (BoC) reports, on the other hand, were more policy-driven, as were the general reports of the General Council, as opposed to those focusing on individual institutions. The BoC, which reported to the Ministry of Health after the latter's formation in 1919, formed a link between the mental hospital system and the state and acted as a conduit for government policy towards the mentally disordered. In

⁴⁷ David Feldman and Jon Lawrence, "Introduction," in *Structures and Transformations in British Historiography*, ed. David Feldman and Jon Lawrence (Cambridge: Cambridge University Press, 2011), 7.

France, asylum directors and chief medical officers reported to the General Council (*Conseil Général*) of the department, an elected body responsible to the Prefect who, operating under the Ministry of the Interior, represented the state at local level.

The professional psychiatric journals of each country, the *Journal of Mental Science* or *JMS* (established in 1855) and the *Annales Médico-Psychologiques* or *AMP* (founded in 1843) were consulted to gain a sense of the important contemporary issues within psychiatry and to ascertain the level of interest in new approaches to patient occupation. These two publications were associated with the Medico-Psychological Association (the MPA became the Royal Medico-Psychological Association, or RMPA, in 1926) in England, and the Société Médico-Psychologique (although the SMP was established after the *AMP*, in 1852) in France. As such, they were the “official” voice of French and English psychiatry. Articles advocating new approaches to patient work written by French psychiatrists also appeared in *L’Aliéniste français*, which was produced by the *Association amicale des Médecins des établissements publics d’aliénés de France*, an association for doctors working in public asylums founded in 1907, and *L’Hygiène Mentale*, the journal of the French League of Mental Hygiene, edited by Édouard Toulouse, co-founder of the French league. *L’Hygiène Mentale* was therefore supportive of the principles of mental hygiene, which included the re-education of patients through occupation, while *L’Aliéniste français* was in favour of asylum reform.

Of particular interest in the British *Journal of Mental Science* was an article by the MS of the Littlemore Hospital, Dr Thomas Saxty Good, in 1930. Based on his address to the Royal Medico-Psychological Association to mark his appointment as the RMPA’s President that year, Good’s article outlines his therapeutic approach and management style. Other useful sources that focused on occupational therapy included Herman Simon’s article in *L’Hygiène Mentale* on his new methods, Adolf Meyer’s paper on “The Philosophy of Occupational Therapy” (1922), the Board of Control’s *Memorandum on Occupation Therapy* (1933), and the chapter on occupational therapy in Henderson and Gillespie’s textbook of psychiatry (1927). The Macmillan Report of 1926 and the French Ministerial Circulars of 1937 and 1938 were also key documents.

What is sadly lacking from the sources is the voice of the patients themselves. Clearly, their views on work and occupational therapy would offer valuable insights, since as Roy Porter reminded us over thirty years ago, histories of medicine should not be written solely from

the physicians' perspective.⁴⁸ Without access to medical records, to which patient letters, notes and journals are sometimes appended, their thoughts on patient work have not been uncovered by this thesis. Institutional annual reports and inspectors' reports give a sense of what life was like for patients – the daily routines, living conditions, the locked doors – but cannot tell us what patients felt about the occupations they were prescribed.

1.9 Methodology

Essentially, this is a transnational study for which both a comparative approach, comparing the uniqueness and similarities between nations, in this case France and England, and an *histoire croisée* approach, investigating the flow and transfer of knowledge between nations, such as between the USA and England, or between Germany and France, are relevant. Marc Bloch, in his seminal paper, "Toward a comparative history of European societies" (first published in 1928), provided one of the founding examples of comparative history.⁴⁹ Bloch's comparative framework enables the historian to assess the validity of explanatory hypotheses and to discover the uniqueness of different societies, not only at a national level, but also at a local level. The explanatory hypothesis to be tested in this thesis is that the adoption of new methods of patient occupation during the interwar period depended on the personal, transnational connections between psychiatrists as well as on the different pathways towards professionalisation taken by French and English psychiatry. In this way, Bloch's approach is helpful in attempting to explain the different trajectories of development of patient work in France and England, and between metropolitan and provincial locations.⁵⁰ In France, the evolution of patient work into occupational therapy was hampered by psychiatry's lack of independence from neurology, financial concerns, management issues and a lack of skilled staff, while in England links between English and American psychiatrists, together with new treatment practices developed during World War I and encouragement from government fostered the adoption of new methods.

⁴⁸ Alexandra Bacopoulos-Viau and Aude Fauvel, "The Patient's Turn. Roy Porter and Psychiatry's Tales, Thirty Years On," *Medical History* 60, no. 1 (2016): 2.

⁴⁹ Marc Bloch, "A Contribution Towards a Comparative History of European Societies," in *Land and Work in Medieval Europe - Selected Papers by Marc Bloch*, ed. J.E. Anderson (Abingdon and New York: Routledge, 1967), 44-81.

⁵⁰ William H. Sewell, "Marc Bloch and the Logic of Comparative History," *History and Theory* 6, no. 2 (1967): 208-18.

The term *histoire croisée*, analysed by Michael Werner and Bénédicte Zimmerman in 2004, refers to a group of histories, normally divided along national lines, which intersect or cross-over, whose relationships with each other are linked socially, culturally or politically.⁵¹ The origins of this new approach can be found, according to Oxford historian Patricia Clavin, in the “study of migration, business, crime and the dissemination of scientific knowledge”.⁵² This approach is particularly relevant to the present study because of the cross-border exchange of information between psychiatrists regarding patient work, with ideas from Switzerland, Germany, Holland and the USA all playing a part in influencing the evolution of patient occupation in France and England. Of particular relevance is Clavin’s emphasis on the importance of personal connections in the establishment of inter- and extra-European relations, that were often very powerful.⁵³ The personal relationship between the American psychiatrist Adolf Meyer and a number of British psychiatrists who trained with Meyer in Baltimore was directly responsible for the transfer of knowledge regarding the American style of occupational therapy. Training in the USA was easier from a linguistic perspective for British psychiatrists than for French doctors; there is no evidence of French psychiatrists training with Meyer. The Parisian psychiatrist, Édouard Toulouse, was unusual for his American connections, which were established via the Mental Hygiene Movement that originated in the USA. Most French psychiatrists paid far more attention to developments regarding patient occupation within Europe, notably Germany and Holland.

New theories emanating from abroad were important in challenging the rationale for patient work, but just as crucially patient work was directly influenced by, if not dependent upon, the local socio-economic and political context outside the institution as well as the prevailing medical context. The social history of medicine, according to Andrew Wear (1993), is a genre that had “come of age” by the early 1990s.⁵⁴ Wear maintains that while the history of medicine had formerly comprised the history of “great doctors, great discoveries and great ideas”, the social history of medicine indicates how medicine affected

⁵¹ Michael Werner and Bénédicte Zimmermann, "Beyond Comparison: Histoire Croisée and the Challenge of Reflexivity," *History and Theory* 1 (2006): 31.

⁵² Patricia Clavin, "Time, Manner, Place: Writing Modern European History in Global, Transnational and International Contexts," *European History Quarterly* 4 (2010): 625.

⁵³ Patricia Clavin, "Defining Transnationalism," *Contemporary European History* 14, no. 4 (2005): 428.

⁵⁴ Andrew Wear, "Introduction," in *Medicine in Society*, ed. Andrew Wear (Cambridge: Cambridge University Press, 1992), 1.

society and how society shaped medicine.⁵⁵ The social history of medicine is closely aligned with social history, with its focus on the experience of the daily lives of ordinary people at home, at work and at leisure and its “expressed desire to examine and reveal the interplay among economics, politics and culture”.⁵⁶ At a time of fundamental change in working practices and economic upheaval, it is perhaps even more important than at other times to study patient occupation inside asylums in the context of social and economic developments outside.

In recent years, social history has moved away from a macro-sociological level of analysis and towards micro-level studies. In particular, macro-level studies of the history of psychiatry tended to focus on discussing psychiatry as a form of “social control”, a framework that has become increasingly unfashionable.⁵⁷ Micro-level studies have attracted criticism, however, for being too narrow and myopic, and for lacking engagement with the wider social and political context.⁵⁸ Mindful of both these warnings, this study aims to present a balanced account that both delves into the detail of patient work in each of the six institutions examined whilst taking account of wider contextual issues. The study seeks to highlight the association between events inside and those outside the institution, which are especially relevant in a study of work which is bound up with the local economy, social customs, politics and gender norms.

Research on a macro level was conducted into the specific influences on psychiatric care and therapeutic regimes. These included socio-economic and political influences such as mental healthcare legislation and welfare legislation, the post-war depression and the Great Depression of the 1930s, new theories regarding the maximisation of labour efficiency and productivity; cultural influences such as contemporary attitudes towards work, employment and unemployment, developments in the social sciences and changing attitudes towards the self, the ideology of eugenics; medical influences such as the treatment of shell-shock

⁵⁵ Ibid.

⁵⁶ Feldman and Lawrence, "Introduction," 7; Mark M. Smith, "Making Sense of Social History," *Journal of Social History* 37, no. 1 (2003): 165.

⁵⁷ Andrew T. Scull, *The Insanity of Place - the Place of Insanity: Essays on the History of Psychiatry* (Abingdon: Routledge, 2006).

⁵⁸ Jonathan Andrews and Anne Digby, "Introduction: Gender and Class in the Historiography of British and Irish Psychiatry," in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, ed. Anne Digby and Jonathan Andrews (Amsterdam, New York: Rodopi, 2004), 13.

during World War I and the Mental Hygiene Movement; and transnational influences, such as the cross-border exchange of knowledge between psychiatrists and attempts to emulate best practice from overseas. How these influences were translated to asylum practice, and their effect on patient work and occupation in the institutions being investigated, is examined in the following chapters.

1.10 Research Questions and Chapter Summaries

Chapter two examines the literature on the history of psychiatry since the early nineteenth century, taking account of the ideological currents (such as the advent of hereditary degeneration theory) and major events (such as World War I) that influenced how psychiatrists interpreted mental disorder. Questions are raised regarding the consequences of vacillations in psychiatric opinion on the origin of mental disorder and on patient occupation. The chapter considers the relatively few studies devoted to patient work, highlighting the fact that no study to date offers a comparison of patient work in French and English institutions during the interwar period. The chapter also explores, in so far as space allows, the literature on work, welfare, new methods of working and worker satisfaction, the focus of which is the world of work outside hospital, but raises the question of the effect of developments in these areas on patient work within hospital.

Before World War I, patient work was only considered suitable, as a distraction, for chronic, incurable and convalescent patients. New theories concerning occupation, emerging from the USA and Germany which reached British and French shores just after the war, challenged these notions suggesting that occupation could be used curatively to treat acute patients. The fundamental question posed by this thesis is how patient occupation in French and English asylums and mental hospitals evolved during the interwar period. Did the practice of patient work remain similar to the way it was organised before World War I? Or did it evolve to incorporate new ways of thinking about occupation, and if so, how did it change and what conditions were required for the change to occur? Chapters three and four attempt to answer these questions by identifying four key areas which were prerequisites for change, namely an ideological shift from an organicist interpretation of mental disorder to a more holistic interpretation based on psychological and social factors, as well as

physiological factors; the establishment of psychiatry as an independent discipline, which required psychiatry and mental health nursing to be professionalised; sufficient economic resources to enable institutions to operate efficiently without relying on the financial contribution made by existing systems of patient work; and issues of hospital management and administration, such as admissions policies, legislation and medical authority, as well as practical matters including adequate facilities and freedom from overcrowding.

The ideological shift from an organicist to a holistic interpretation of mental disorder, and issues of professionalisation are explored in chapter three. It is argued in this chapter that the different pathways to professionalisation taken by French and English psychiatry, and French psychiatry's close alignment to neurology, led to psychiatrists in France and England to hold divergent views regarding the therapeutic value of patient occupation. The treatment of soldiers suffering from war neuroses during World War I exposed and compounded the differences in the French and English interpretations of mental disorder. Amongst English psychiatrists, the war stimulated the development of psychological approaches to treating mental disorder; work and occupational therapy proved to be beneficial for soldiers suffering from shell-shock, both at treatment centres near the Front and at army base hospitals.⁵⁹ French psychiatrists, on the other hand, interpreted war neuroses as a form of hysteria, and turned to the physical methods of treatment associated with neurology.

After the war, French psychiatrists continued to maintain that mental disorder had an organic or physiological basis, for which psychological treatments such as occupation were not deemed to be effective. In England, on the other hand, where psychiatrists increasingly accepted that mental disorder could have a psychological or social origin, linked to problems of adaptation to the environment, psychological means of treatment, including occupation, were considered beneficial. A more holistic approach to mental disorder was reinforced by the preventative agenda of the Mental Hygiene Movement, which originated in the USA. The principles of mental hygiene, which were focused on solving individuals' problems of adaptation to the environment through re-education (for which occupation was an important means of therapy) and psychotherapy, were well received by English

⁵⁹ Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War*, Maudsley Monographs (Hove and New York: Psychology Press, 2005), 31-2.

psychiatrists. They were also well received by a small group of psychiatrists in Paris, led by Édouard Toulouse, but the influence of the movement and its principles were restricted to the metropolis. Most French psychiatrists retained an organicist approach towards mental disorder and preferred biological over psychological methods of treatment.

Professionalisation both within psychiatry and mental nursing is considered in chapter three. It is argued that the development of specialist training, qualifications and standards were crucial to creating an environment in which the new methods of therapeutic occupation emerging in the USA and Germany could be introduced and delivered successfully. In England, the Diploma in Psychological Medicine, the first specialist qualification for English psychiatrists, was established in 1912, while French psychiatry would have to wait until 1968 for a similar qualification to be developed. Until then, French psychiatry continued to be closely aligned with neurology (and its organicist interpretation of mental disorder) as a means of boosting its professional credibility. Mental nurse training was not widely available in France and mental nurses lacked the education, commitment and skills to oversee the provision of occupational therapy, as opposed to traditional methods of patient work. Training for their English counterparts, on the other hand, was available nationwide and nursing standards were higher in England.

In addition to the ideological shift outlined above, professional independence and high nursing standards, certain conditions had to be met with regard to admissions policies, legislation, staffing, asylum management structures and financial resources. Chapter four compares how these conditions were met in England and France. The separation of care for curable and incurable cases prompted a re-evaluation of the use of occupation in English mental hospitals. The adoption of occupation therapy was recommended in English mental hospitals, while in institutions for incurable patients, work continued to be used as a means of distraction and of offsetting institutional running costs. In France separate facilities for incurable patients were only available for patients from the Seine, but at the Asile Clinique in Paris, which specialised in acute patients from 1928, work was not re-assessed in the same way as in England. The adoption of new methods of occupation depended to a large extent on the treatment preferences of the chief medical officer (CMO) or medical superintendent (MS); most French CMOs, including those at the Asile Clinique, remained organicist in outlook and did not prioritise occupation as a means of active treatment.

A crucial difference between patient work in French and English institutions was the fact that in France, institutions were obligated by law to provide work, occupation and recreational activities for patients.⁶⁰ Yet, even though the French legislation made clear that the doctor decided who should work and at what type of work, conflict arose between Asylum Directors (ADs) and CMOs over the deployment of patient workers, based on an uneasy relationship between therapy and economy. Asylum finances were difficult to reconcile in the turbulent economic climate of the interwar period. World War I had been extremely costly, in both human and economic terms, particularly for France. Inflation soared in both Britain and France during the 1920s.⁶¹ Tight local authority budgets, coupled with dramatic price fluctuations, put pressure on asylum budgets. It is argued that the importance of patient work as a means of offsetting institutional running costs over-rode its value as a therapy in France. This emphasis on the financial contribution made by patient work led to a reluctance to change the way in which patient work was organised in France. In England, where hospital budgets were not quite so tight, the financial benefits of patient work were downplayed in favour of the therapeutic benefits for the patient. This was underlined in the Macmillan Report, produced in 1926 following the investigations of a Royal Commission into the care of the mentally ill.⁶²

The Royal Commission of 1924/6 had been cited in response to condemnation of the English asylum system by Dr Montagu Lomax in his book, *Experiences of an Asylum Doctor* (1921). This inflammatory account had included criticism of the existing system of patient work, which he described as exploitative and degrading, based on his experience working at an asylum in Lancashire.⁶³ The French system of patient work also attracted criticism from some French psychiatrists who compared it unfavourably with the methods used in neighbouring countries, notably Switzerland and Holland. These criticisms arrived at around the same time that new theories of German and American occupational therapy began to attract attention in France and Britain. Greater interest amongst English psychiatrists in the American style of OT is attributed to the fact that British psychiatry was influenced by the

⁶⁰ According to the law of 1838, passed when moral therapy was still enjoying its hey-day, re-affirmed in the amended legislation of 1857.

⁶¹ Derek H. Aldcroft, *The European Economy 1914-2000*, Fourth ed. (London and New York: Routledge, 2001), 30-33.

⁶² Report of the Royal Commission on Lunacy and Mental Disorder (London: HMSO, 1926).

⁶³ Montagu Lomax, *Experiences of an Asylum Doctor* [1921], (New Delhi: Isha Books, 2013).

American model of psychiatric care, according to the principles of the Mental Hygiene Movement, while French interest in the German version of OT (known as “more active therapy” or MAT) is linked to political and scientific Franco-German rivalry.

Chapters five and six address the question of whether these new methods of OT were adopted by English and French institutions. Patient occupation within the metropolitan institutions of the Asile Clinique, the Henri Rousselle Hospital (HRH) in Paris, and the Bethlem Royal and the Maudsley in London is the focus of chapter five. All these hospitals catered for acute, potentially curable cases of mental illness. The Maudsley and the HRH were both in the unique position (for their respective countries) of admitting mild, incipient cases on a voluntary basis. As indicated above, before World War I, patient work had been considered unsuitable for patients at the acute stage of their illness, so this institutional focus on acute cases had important implications for patient occupation. Whilst new theories regarding the suitability of occupation for acute-stage patients emerged after the war (assessed in chapter four), not all psychiatrists were either willing or able to put them into practice. Practical difficulties, such as staff ratios, nursing skills, economic factors and overcrowding, together with a preference for biological means of treatment for acute cases, based on an organicist interpretation of mental disorder, impeded the take-up of new methods in France. In England, the new methods of occupational therapy (OT) suitable for acute patients were more readily adopted; the reasons for this include psychiatrists’ holistic approach to mental disorder, and close links with the American psychiatrist Adolf Meyer, an early-adopter and advocate of OT; medical authority over the hospital treatment regime; a reduced emphasis on the financial benefits of patient work; high nursing standards and a lack of overcrowding. Similar issues, but with different emphases, were found to affect patient occupation in provincial institutions.

Chapter six addresses patient work in the provincial institutions of the Asile de la Sarthe (ADLS) in Le Mans, France and the Oxford and County City Mental Hospital (the Littlemore) in England. These institutions catered for a mixed clientele of both acute, chronic and incurable patients. Work had been considered suitable for calm, chronic patients, as well as convalescents since the nineteenth century, so a greater proportion of provincial patients might be expected to work than in the metropolitan institutions, irrespective of attempts to introduce new methods of OT. However, occupational therapy, as well as traditional patient

work, was also practised at the Littlemore Hospital, engaging acute and agitated chronic patients, and providing a useful supplement to psychotherapy. Class issues were highlighted at the ADLS, where a quarter of patients were private; a much smaller proportion of private patients (particularly the women) worked despite the alleged therapeutic benefits of work and occupation. Overcrowding (in the public part of the institution) was a serious impediment to the adoption of new methods of patient occupation, but this was not something that the ADLS CMOs appeared to prioritise, preferring to focus on biological treatments for acute patients, while chronic and convalescent patients pursued work along traditional lines.

Chapters five and six also ask whether traditional methods of patient work or the new methods of occupational therapy prepared patients for the local labour market after discharge? The evidence points to a striking similarity between French and English institutions and between metropolitan and provincial institutions. Neither in France nor England were patients prepared for new working practices or for the types of work available to them locally on discharge. Patient work in France continued to be tied to the needs of the institution, which relied on patient labour to keep running costs low. These institutional requirements had not changed significantly since the late nineteenth century, so neither did the type of work given to patients, despite developments in industry and services outside the institution. In England, the type of occupational therapy practised in the institutions studied was based on arts and crafts and was arguably even further from local industrial practices than work around the hospital. This was related to the greater emphasis on curative occupation rather than rehabilitation; the latter could take place outside hospital under the auspices of outpatient facilities, psychiatric social workers and voluntary organisations offering support (which were more widely available in the cities than in the provinces). It was also influenced by changing attitudes that no longer framed unemployment in terms of moral failing or individual fault.

Another question posed by chapters five and six was whether, when new medical treatments for mental illness emerged during the 1920s and 1930s, occupation remained relevant as a treatment, and if so, how was it used in conjunction with these new medical interventions? The new treatment methods, including malaria therapy, insulin coma therapy, Cardiazol and electro-convulsive therapy (ECT), revolutionised care for the mentally

ill and ended what Edward Shorter has described as “the therapeutic nihilism that had dominated psychiatry in previous generations”.⁶⁴ These new methods were enthusiastically adopted in France, where there was a preference for biological methods of treatment and where occupation was reserved for chronic, incurable and convalescent patients. French CMOs providing malaria therapy to patients suffering from general paralysis of the insane (GPI) noted that patients in remission were able to join the patient workforce whilst convalescing from the treatment. The new methods were treated with more caution in England where MSs were sceptical about treatments whose efficacy had yet to be proven and who were more inclined to prescribe psychotherapy and OT.

Finally, chapter six highlights the differences and similarities between asylum practices in provincial and metropolitan areas, where different socio-economic conditions pertained. In England the difference between patient occupation in London and Oxford was less marked than that between Paris and Le Mans. In all the English institutions, most patients were occupied, either working around the hospital or engaged in OT; the difference lay in the proportions engaged in each type of activity, with more patients working around the hospital in Oxford than London. In France the difference was more obvious, with many more patients working in Le Mans than Paris. This was because at the Asile Clinique, which specialised in acute cases, occupation was not prescribed to acute patients except at the convalescent stage of their illness. The situation was rather different at the HRH, but no figures were given for the numbers of patients engaged in occupation. Class was also an issue that singled out the paying patients at Bethlem and the ADLS. Manual labour was not considered suitable for the middle classes, so very few ADLS patients worked. Unlike their counterparts at Bethlem, however, they did not have the option of OT or such a comprehensive entertainments programme to keep them busy. Chapter seven draws all these observations together, setting out the key findings of this thesis, and highlighting where these help to fill gaps in the existing literature.

⁶⁴ E. Shorter, *A History of Psychiatry from the Era of the Asylum to the Age of Prozac* (New York and Chichester: Wiley, 1997), 194.

Chapter 2:

Literature Review

2.0 Introduction

Patient work has comprised an important part of asylum and mental hospital regimes since the early nineteenth century, but until recently it has not received in-depth scholarly analysis. Historians of psychiatry have tended to focus on such topics as the rise of the asylum and the emergence of moral therapy, the evolution of medical ideas, the treatment of shell-shock during World War I, the histories of institutions and the contributions of individual psychiatrists, but patient work – whilst fundamental to many of these topics – has been largely overlooked as a subject for study in its own right. Waltraud Ernst (2016) begins to address this lacuna with an edited volume that examines patient work in a range of psychiatric institutions and considers “the meaning of work in relation to its specific sociocultural, economic and political contexts”.¹ However, there remains a dearth of studies focusing on the interwar period and to date there is no comparative study of patient work in French and English institutions.

A study of patient work within mental hospitals must take account of the literature regarding work and welfare, as well as psychiatry, as both directly impacted on the practice of work both within hospital and outside it. The nature of attitudes towards employment and unemployment, working methods, and notions of worker satisfaction framed the experience of the patient entering (and leaving) hospital and that of the doctor prescribing work. The changing theories regarding the origin and treatment of mental disorder that informed psychiatric practice also had a bearing on whether work and occupation were prescribed for their therapeutic, rehabilitative or economic values. Psychiatrists adopting a holistic interpretation of mental disorder, or those who took account of both psychological and physiological aspects of the condition, were more likely to view patient work therapeutically than psychiatrists wedded to an organicist perspective. The different perspectives held by French and British interwar psychiatrists led to a divergence in approaches to patient work, an area that has been underexplored to date.

¹ W. Ernst, "Therapy and Empowerment, Coercion and Punishment: Historical and Contemporary Perspectives on Work, Psychiatry and Society," in *Work, Psychiatry and Society, C.1750-2015*, ed. Waltraud Ernst, 1.

Part I: Literature on Psychiatry

2.1.1 The Rise of the Asylum and Moral Therapy

Most histories of psychiatry in the West focus on the late-eighteenth and nineteenth centuries, a period characterised by the rise of the asylum and by new ways of treating the insane according to the humanitarian principles of the Enlightenment. “Moral treatment” became the treatment method to which most asylum doctors aspired. The therapy concentrated on the rational and emotional, rather than the organic causes of insanity, aiming to build up patients’ self-esteem and self-restraint, thereby equipping them with sufficient self-discipline to master their condition.² Integral to moral treatment was giving patients some form of work, such as assisting the attendants with their duties or working in the fields or gardens.³ Patient work was, according to sociologist Andrew Scull (1993), a “major cornerstone” of nineteenth-century moral treatment, while historian of psychiatry Leonard Smith (2007) describes it as “a rationalised central element of therapy and rehabilitation in public lunatic asylums”.⁴ That is not to say that patients only worked in institutions where moral therapy was practised; but the work prescribed within the context of moral therapy was deemed to be therapeutic.

The merits of moral treatment, and thus of patient work, have been the topic of vigorous debate among historians. Psychiatric practitioners writing the history of their profession in the 1930s, 1940s and 1950s, extolled the virtues of moral treatment as the harbinger of a new humanitarian era.⁵ In his *Histoire de la Folie* (1961), Michel Foucault questions the alleged benign nature of moral therapy, and rejected the notion of liberal humanism in nineteenth-century psychiatry, medicine and penal reform. In his view, “moral therapy” merely replaced physical abuse with mental abuse.⁶ Seen through Foucault’s lens, the

² Anne Digby, “Moral Treatment at the Retreat, 1796-1846,” in *The Anatomy of Madness: Essays in the History of Psychiatry*, ed. W.F. Bynum, Roy Porter, and Michael Shepherd (London and New York: Tavistock, 1985), 53.

³ By way of an example, the work regime at the York Retreat where moral therapy was pioneered by William Tuke (1732-1822), is outlined by Digby in: *ibid.*, 52-72.

⁴ Leonard Smith, *Lunatic Asylums in Georgian England 1750-1830* (London and New York: Routledge, 2007), 156; Andrew Scull, *The Most Solitary Of afflictions: Madness and Society in Britain, 1700-1900* (New Haven and London: Yale University Press, 1993), 102.

⁵ Roy Porter, “Introduction: Reflections on Psychiatry and Its Historians,” in *Discovering the History of Psychiatry*, ed. Mark Micale and Roy Porter (Oxford and New York: Oxford University Press, 1994), 5-6.

⁶ *Ibid.*, 23.

asylum was therefore a means of moulding inmates into willing, acquiescent workers, ready to contribute to the state's economic requirements. Foucault characterised work within the asylum as "a constraining power superior to all forms of physical coercion" due to the regularity of the hours, the need to pay attention, and the obligation to produce results.⁷ Work carried out by inmates was "deprived of any productive value", imposed as "moral rule, a limitation of liberty, a submission to order, an engagement of responsibility" designed to rid the mind of "of all exercises of the imagination" and supplant "delirious illusions".⁸ According to Andrew Scull, writing in the late 1970s, the asylum system was designed to "repair damaged human capital", to instil bourgeois values of self-control, self-sufficiency and productivity through a programme of "moral therapy", and to "warehouse" those unable to support themselves.⁹

A new generation of scholars turned away from arguments focusing on negative aspects of social control to embrace what Joseph Melling has termed a late-Whiggish position on the nineteenth-century asylum, suggesting its function was more benign.¹⁰ Historians of psychiatry Leonard Smith, Akihito Suzuki and David Wright, contributors to Melling's edited volume (1999), present the asylum as a therapeutic establishment that responded to community needs.¹¹ In their study of the Welsh asylum at Denbigh (1999), Pamela Michael (historian of psychiatry) and David Hirst (historian of social policy) assert that "the operational philosophy of the asylum was based on the 'rule of kindness'".¹² These more recent studies, based on the detailed study of institutional practices, indicate that the pendulum has swung back towards a more compassionate interpretation of the asylum. The present study of patient occupation helps to clarify the extent to which the mental hospital fulfilled a political aim of turning pauper patients into productive workers, and whether the

⁷ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (New York: Random House, 1965), 247.

⁸ *Ibid.*, 248.

⁹ Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979), 94.

¹⁰ Joseph Melling, "Accommodating Madness: New Research in the Social History of Insanity and Institutions," in *Insanity, Institutions and Society, 1800-1914*, ed. Joseph Melling and Bill Forsythe (London and New York: Routledge, 1999), 14.

¹¹ *Ibid.*, 22.

¹² Pamela Michael and David Hirst, "Establishing the 'Rule of Kindness': The Foundation of the North Wales Lunatic Asylum, Denbigh," in *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective*, ed. Joseph Melling and Bill Forsythe (London and New York: Routledge, 1999), 171.

primary rationale for the prescription of patient work was to offset institutional running costs, or to provide therapy for the benefit of the patient.

2.1.2 Degeneration Theory and an Organicist Interpretation of Mental Disorder

The aim of turning paupers into active citizens can be linked to a national pre-occupation with social deviance on the one hand, and with national efficiency on the other hand. Both these concepts had an important implication for patient work and its relative importance as a means of therapy, economy and rehabilitation. The link between the notion of “social deviance”, a major source of concern amongst the populations of nineteenth-century Western Europe, and degeneration theory, is emphasised by Robert Nye (1984).¹³ Most forms of social deviance, including crime, alcoholism, prostitution, suicide and other social pathologies such as joblessness, were believed to have a biological origin and constituted evidence of degeneration. One of the particular advantages of the degeneration theory to psychiatrists, according to Ian Dowbiggin (1991), was its capacity to justify the existence of the asylum, and the asylum physician’s claims to expertise, not only concerning mental disorder, but also concerning other forms of social deviance.¹⁴ Nye maintains that by the 1880s and 1890s, the behaviours associated with social deviance gradually became “medicalised” as doctors extended their area of expertise to include formerly non-medical fields.¹⁵ Whether this extension of doctors’ sphere of influence to incorporate poverty, and by association joblessness, influenced the prescription of patient work and occupation by interwar psychiatrists is not addressed by the existing literature, a lacuna to be filled by the present study.

Ernest Abel (2004), maintains that the degeneration theory put forward by Bénédict-Augustin Morel in 1857 enjoyed widespread and prolonged support amongst both French and British psychiatrists because it provided psychiatry with a “convincing biological

¹³ Robert Nye, *Crime, Madness and Politics in Modern France: The Medical Concept of National Decline* (Princeton, NJ: Princeton University Press, 1984).

¹⁴ Ian R. Dowbiggin, *Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth-Century France* (Berkeley and Oxford: University of California Press, 1991), 164.

¹⁵ Nye, *Crime, Madness and Politics in Modern France*, xi.

explanation” – in the absence of any other – about how mental disease was acquired.¹⁶ Morel’s theory, that a neuropathic predisposition to mental disorder originating from the “pathogenic modern social environment” was transmitted through heredity, soon dominated interpretations of mental illness by psychiatrists.¹⁷ The therapeutic pessimism surrounding degeneration theory led to a concept of the asylum as a custodial institution, where patients were routinely managed rather than cured. The growing preponderance of somatic-pathological approaches led to a corresponding tendency to disparage any kind of psychological approach, including moral treatment and patient work, to mental disorders.¹⁸ As Joan Busfield (1986) explains, the “intellectual foundations on which medical support for moral treatment had been built were crumbling”.¹⁹ Identifying the physiological causes of mental disorder was prioritised over the creation of a therapeutic environment.²⁰ This was to have important consequences for the conception of patient work as therapy. The theory of degeneration continued to enjoy support well into the early twentieth century, although World War I challenged purely organicist interpretations of mental disorder.

2.1.3 Psychiatry during World War I

Chris Feudtner (1993) cautions against the traditional, and in his eyes overly simplistic, interpretation of psychiatry in World War I which maintains that before the war all British psychiatrists were organicists and that afterwards they all became psychologists. He concedes, however, that the war did much to convince British psychiatrists of the value of a psychological approach.²¹ In France, psychiatry’s close alignment with neurology resulted in

¹⁶ Ernest Abel, "Bénédict-Augustin Morel (1809-1873)," *American Journal of Psychiatry* 161, no. 12 (2004): 2185.

¹⁷ Ian Dowbiggin, "Degeneration and Hereditarianism in French Mental Medicine 1840-90: Psychiatric Theory as Ideological Adaptation," in *The Anatomy of Madness: Essays in the History of Psychiatry*, ed. W. F. Bynum, Roy Porter, and Michael Shepherd (London and New York: Tavistock Publications, 1985), 188, 92.

¹⁸ Michael J. Clark, "The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry," in *Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 271.

¹⁹ Joan Busfield, *Managing Madness: Changing Ideas and Practice* (London and Melbourne: Hutchinson, 1986), 281-2.

²⁰ *Ibid.*, 282.

²¹ Chris Feudtner, "'Minds the Dead Have Ravished': Shell-Shock, History and the Ecology of Disease-Systems," *History of Science* 31, no. 4 (1993): 337-420.

“adhesion to an organic model of mental illness” both during the war and afterwards.²² “Shell-shock”, as war neuroses became known by British contemporaries, has been the focus of study by most British historians of psychiatry with an interest in World War I.²³ Some recent studies have focused on issues of masculinity and resilience.²⁴ Others have addressed the wider concept of neurasthenia and war trauma, which includes the shell-shock experienced during World War I in addition to nervous conditions associated with the stress of modern living and other modern conflicts.²⁵ Few of these studies pay more than passing attention to the role of work in the treatment of soldiers suffering from shell-shock, although occupation formed an important aspect of the therapeutic arsenal of British military psychiatry.

In contrast to shell-shock among British soldiers, war neurosis amongst French soldiers has been far less well researched. This may be due to the fact that for a long time, official records regarding the often aggressive treatment of war neuroses were suppressed.²⁶ It is only in the twenty-first century that in-depth studies have been conducted, such as those by Marc Roudebush (2001), Laurent Tatu and Julien Bogousslavsky (2012), Hervé Guillemain (2013), Marie Derrien (2015) and Anne Creton (2015).²⁷ Roudebush argues that psychiatrists

²² Jean-Christophe Coffin, ““Misery and Revolution”: The Organisation of French Psychiatry, 1900-1980,” in *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century, Comparisons and Approaches*, ed. M. Gijswijt-Hofstra, H. Oosterhuis and J. Vijselaar (Amsterdam: Amsterdam University Press, 2005), 227.

²³ Among the most recent studies of shell shock are: Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (Basingstoke: Palgrave Macmillan, 2002); Tracey Loughran, “Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and Its Histories,” *Journal of the History of Medicine & Allied Sciences* 67, no. 1 (2012): 94-119; Fiona Reid, *Broken Men: Shell Shock, Treatment and Recovery in Britain, 1914-1930* (London: Continuum, 2010); Hervé Guillemain and Stéphanie Tison, *Du Front À L'asile, 1914-1918* (Paris: Alma éditeur, 2013); Marc Roudebush, “A Battle of Nerves: Hysteria and Its Treatments in France During World War I,” in *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age, 1870-1930*, ed. Paul Lerner and Mark S. Micale (Cambridge: Cambridge University Press, 2001), 253-79; Paul Lerner, *Hysterical Men: War, Psychiatry and the Politics of Trauma in Germany, 1890-1930* (Ithaca, NY: Cornell University Press, 2003).

²⁴ For example: Jessica Meyer, *Men of War: Masculinity and the First World War in Britain* (Basingstoke: Palgrave Macmillan, 2009).

²⁵ Mark S. Micale and Paul Frederick Lerner, *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930*, Cambridge Studies in the History of Medicine (Cambridge: Cambridge University Press, 2001); Jones and Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War*; Lerner, *Hysterical Men: War, Psychiatry and the Politics of Trauma in Germany, 1890-1930*.

²⁶ Julien Bogousslavsky and Laurent Tatu, “French Neuropsychiatry in the Great War: Between Moral Support and Electricity,” *Journal of the History of the Neurosciences* 22 (2013): 145.

²⁷ Roudebush, “A Battle of Nerves,” 253-79; Laurent Tatu and Julien Bogousslavsky, *La Folie Au Front: La Grande Bataille des Névroses De Guerre (1914-1918)* (Paris: Éditions Imago, 2012); Guillemain and Tison, *Du Front À L'asile, 1914-1918*; Marie Derrien, ““La Tête En Capilotade”: Les Soldats De La Grande Guerre Internés Dans Les Hôpitaux Psychiatriques Français (1914-1980)” (Université Lyon 2, 2015); Anne Creton, “Psychiatrie

treating war neuroses in France “readily drew on the lexicon of hysteria and its associated conditions”, thereby demonstrating the enduring influence of neurology on French psychiatry.²⁸ The treatment methods used by military neuro-psychiatrists were based on the concept of “pithiasms”, developed by neurologist Joseph Babinski, involving techniques of persuasion, rather than in-depth psychological methods.²⁹ The studies by Roudebush, Guillemain and Derrien indicate that work was not a significant feature in the treatment regimes for war traumatised soldiers in France.

2.1.4 Work Therapy

Patient work is often described in studies focusing on individual asylums,³⁰ or on moral treatment,³¹ but is rarely assessed in its own right, despite its centrality to the daily asylum regime. Waltraud Ernst’s edited volume (2016) adds to existing studies by Véronique Fau-Vincenti (2014), J-P. Arveiller and Clément Bonnet (1991); Jennifer Laws (2011); Heli Leppaelae (2013); Vicky Long (2013, 2006); Geoffrey Reaume (2006); and Jean-Pierre Goubert and Rémi Remondière (2004).³² These studies examine the relationship between

Française Et Première Guerre Mondiale: Évolution Des Idées Et Situation Au Sein Des Établissements De Soins Du Nord-Pas-De-Calais" (Université de Lille, 2015).

²⁸ Roudebush, "A Battle of Nerves," 254.

²⁹ Ibid.

³⁰ Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985); Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrew's Hospital, 1810-1998* (Woodbridge: Boydell, 2003); D. Gittins, *Madness in Its Place: Narratives of Severalls Hospital, 1913-1997* (London and New York: Routledge, 1998); Andrews et al., *The History of Bethlem*; John Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum - St John's* (London: Gaskell, 1990); Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London: Routledge, 1992).

³¹ Roy Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (Harmondsworth: Penguin, 1990); "Was There a Moral Therapy in Eighteenth-Century Psychiatry?," *Lychnos* (1981-2): 12-26; Digby, "Moral Treatment at the Retreat, 1796-1846," 52-72; Alexander Walk, "Some Aspects of the 'Moral Treatment' of the Insane up to 1854," *Journal of Mental Science*, no. 421 (1954): 807-37; Eric Carlson and Norman Dain, "The Psychotherapy That Was Moral Treatment," *The American Journal of Psychiatry*, no. 117 (1960): 519-24; Donald Gerard, "Chiarugi and Pinel Considered: Soul's Brain/Person's Mind," *Journal of the History of the Behavioral Sciences* 33, no. 4 (1997): 381-403; Louis Charland, "Benevolent Theory: Moral Therapy at the York Retreat," *History of Psychiatry*, no. 18 (2007): 61-80; Jane Freebody, "The Role of Work in Late Eighteenth- and Early Nineteenth-Century Treatises on Moral Treatment in France, Tuscany and Britain," in *Work, Psychiatry and Society, C.1750-2015*, ed. Waltraud Ernst (Manchester: Manchester University Press, 2016), 31-54.

³² Ernst, *Work, Psychiatry and Society*; Véronique Fau-Vincenti, "Valeur Du Travail À La Troisième Section De L'hôpital De Villejuif: Entre Thérapie et Instrument de Discipline," *Savoirs, Politiques et Pratiques de l'exécution des peines en France au XXe siècle* (2014), <http://criminocorpus.revues.org/2788>; Laws, "Crackpots and Basket-Cases," 65-81; Heli Leppaelae, "Duty to Entitlement: Work and Citizenship in the Finnish Post-War Disability Policy, Early 1940s-1970s," *Social History of Medicine* 27, no. 1 (2013): 144-64; Vicky Long, ""A

the meaning of work *inside* the asylum and the socio-economic, cultural and political contexts *outside*. Some of the studies highlight how the rationale for patient work changed over time. Anne Digby (1985), for example, demonstrated that the rationale for patient work at the Retreat at York changed from therapy at the beginning of the nineteenth century, when it was introduced in the context of moral treatment, to discipline and control by the century's end.³³ Such a change can be linked to the accumulation of chronic cases on the one hand, and to changing perspectives on the origin and curability of mental disorder on the other. The replacement of a therapeutic rationale by an economic one is highlighted by Ernst, Reaume, Walsh and Moran who reveal that as asylum budgets became increasingly restricted, patient work offered a means of making substantial cost-savings.³⁴ Reaume maintains that moral therapy became "a public works programme run on the 'free' labour of people confined in insane asylums".³⁵ In British-held territories in Asia, the early rhetoric of patient work, linked to moral therapy with its emphasis on compassion and humane treatment, changed towards the end of the nineteenth century, with an increased focus on combating idleness, as Ernst highlights.³⁶ Harris charts the rise and fall of faith in work therapy in North America, noting how the therapeutic optimism of the early nineteenth century gave way to a loss of confidence in the efficacy of therapeutic work towards the end of the century, as asylums evolved from curative to custodial institutions.³⁷

Satisfactory Job Is the Best Psychotherapist": Employment and Mental Health 1939-1960," in *Mental Illness and Learning Disability since 1850: Finding a Place for Mental Disorder in the United Kingdom*, ed. J. and P. Dale Melling (Abingdon: Routledge, 2006), 179-99; "Rethinking Post-War Mental Health Care: Industrial Therapy and the Chronic Mental Patient in Britain," *Social History of Medicine* 26, no. 4 (2013): 738-58; Geoffrey Reaume, "Patients at Work: Insane Asylum Inmates' Labour in Ontario, 1841-1900," in *Mental Health in Canadian Society: Historical Perspectives*, ed. James Moran and David Wright (Montreal: McGill Queen's University Press, 2006), 69-116; J.-P. Arveiller and Clément Bonnet, *Au Travail, Les Activités Productives Dans Le Traitement Et La Vie Du Malade Mental* (Toulouse: ERES, 1991); Jean-Pierre Goubert and Rémi Remondière, "Les Origines Historiques De L'ergothérapie En France," *Revue Sociologie Santé* 20 (2004): 247-68.

³³ Digby, *Madness, Morality and Medicine*, 130.

³⁴ Waltraud Ernst, "Useful Both to the Patients as Well as to the State': Patient Work in Colonial Mental Hospitals in South Asia, C.1818-1948," in *Work, Psychiatry and Society, C.1750-2015*, ed. Waltraud Ernst (Manchester: Manchester University Press, 2016), 117-41; Thomas Mueller, "Between Therapeutic Instrument and Exploitation of Labour Force: Patient Work in Rural Asylums in Wuerttemberg, C.1810-1945," *ibid.*, 220-37; James Moran, "Travails of Madness: New Jersey, 1800-1870," *ibid.*, 77-96; Reaume, "Patients at Work," 69-116.

³⁵ Reaume, "Patients at Work," 90.

³⁶ Ernst, "Useful Both to the Patients as Well as to the State'," 122.

³⁷ Ben Harris, "Therapeutic Work and Mental Illness in America, C.1830-1970," in *Work, Psychiatry and Society, C.1750-2015*, ed. Waltraud Ernst (Manchester: Manchester University Press, 2016), 56.

In other studies of patient work, the prescription of work was variously justified on the grounds of tackling malingering,³⁸ encouraging the poor to fulfil their civic duty,³⁹ instilling fresh attitudes towards work and productivity,⁴⁰ ensuring that criminal patients made a contribution to their care,⁴¹ and preventing incurable patients from being a “burden to the state” in difficult economic circumstances.⁴² The present thesis builds on these studies of patient work, assessing the factors that shaped patient work and occupation in the mid-twentieth century, highlighting how different rates of change taking place within French and English psychiatry and mental nursing; different economic circumstances; and contrasting management structures within asylums contributed to patient work developing differently in the two countries.

2.1.5 Work in the Context of Other Treatments

Psychiatry, according to Edward Shorter, has always been torn between two views of mental illness, one situating the origin of mental illness in the biology of the cerebral cortex, and the other attributing symptoms to “psychosocial” aspects of patients’ lives.⁴³ Attempts by psychiatrists to attribute mental disorder to the body has led to a fascination with somatic treatments, to the extent that many historians of psychiatry have focused their attention on physical or physiological rather than on psychological treatments.⁴⁴ Historians focusing on the histories of psychological methodologies (other than moral therapy), constitute “exceptions to the norm” according to Scull.⁴⁵ These historians include Henri Ellenberger (1970), Rhodri Hayward (2014), Annick Ohayon (1999), Ludy Benjamin (2007) and J. Carroy

³⁸ Sarah Chaney, "Useful Members of Society or Motiveless Malingerers? Occupation and Malingering in British Asylum Psychiatry, 1870-1914," *ibid.*, ed. Waltraud Ernst, 277-97.

³⁹ Sonja Hinsch, "They Were 'Improved', Punished and Cured: The Construction of 'Workshy', 'Industrious' and (Non-)Compliant Inmates in Forced Labour Facilities in the First Republic of Austria between 1918 and 1933," *ibid.*, ed. Waltraud Ernst, 262-76.

⁴⁰ M. Ankele, "The Patient's View of Work Therapy: The Mental Hospital Hamburg-Langenhorn During the Weimar Republic," *ibid.*, ed. Waltraud Ernst, 238-61.

⁴¹ Fau-Vincenti, "Valeur Du Travail À La Troisième Section De L'hôpital De Villejuif".

⁴² Yolanda Eraso, "'A Burden to the State': The Reception of the German 'Active Therapy' in an Argentinian 'Colony-Asylum' in the 1920s and 1930s," in *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, C.1800-2000.*, ed. Waltraud Ernst and Thomas Mueller (Cambridge: Cambridge Scholars Publishing, 2010), 51-79.

⁴³ Shorter, *A History of Psychiatry*, 26.

⁴⁴ Andrew Scull, "Somatic Treatments and the Historiography of Psychiatry," *History of Psychiatry* 5 (1994): 4-5.

⁴⁵ *Ibid.*, 5.

et al. (2006).⁴⁶ Histories of somatic approaches have focused on the emergence of a number of physical interventions during the interwar period, including malarial fever therapy (discovered as an effective treatment for general paralysis of the insane (GPI) in 1917); prolonged sleep therapy; Insulin Coma Therapy (ICT); Cardiazol therapy; Electro-convulsive therapy (ECT); focal sepsis and lobotomy or leucotomy.⁴⁷ A focus on individual treatments fails to take account of their use in relation to other treatments, such as patient work. This is explored by the present thesis.

Mark Micale (2000) has suggested that the use of “heroic” physical treatments during the interwar period was born out of “desperation” to identify effective cures for mental disorder. He saw it as “an aggressive attempt by psychiatry to embrace the medical mainstream”.⁴⁸ The present thesis compares the different attitudes towards adoption of these physical treatments by French and English psychiatrists. The greater enthusiasm for them amongst French psychiatrists was indicative of the slower pace of professionalisation of French psychiatry and its ongoing close alignment with the profession of neurology, which sought biological or physical treatment solutions.

⁴⁶ Henri F. Ellenberger, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* (London: Fontana, 1994); Rhodri Hayward, *The Transformation of the Psyche in British Primary Care, 1880-1970* (London and New York: Bloomsbury, 2014); Annick Ohayon, *L'impossible Rencontre: Psychologie Et Psychanalyse En France 1919-1969* (Paris: Éditions la Découverte & Syros, 1999); Ludy T. Benjamin, *A Brief History of Modern Psychology* (Oxford: Blackwell, 2007); J. Carroy, Annick Ohayon, and Régine Plas, *Histoire De La Psychologie En France (19e - 20e Siècles)* (Paris: La Découverte, 2006).

⁴⁷ G. Windholtz and Witherspoon L. H., "Sleep as a Cure for Schizophrenia: A Historical Episode," *History of Psychiatry*, no. 4 (1993): 83-93; Doroshov Deborah Blythe, "Performing a Cure for Schizophrenia: Insulin Coma Therapy on the Wards," *Journal of the History of Medicine and Allied Sciences* 62, no. 2 (2007): 213-43; Niall McCrae, "A Violent Thunderstorm: Cardiazol Treatment in British Mental Hospitals," *History of Psychiatry* 17, no. 1 (2006): 67-90; G. E. Berrios, "Early Electroconvulsive Therapy in Britain, France and Germany: A Conceptual History," in *150 Years of British Psychiatry, Volume 2: The Aftermath*, ed. H. L. Freeman and G. E. Berrios (London: Athlone Press, 1996), 3-15; Elliot Valenstein, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (London and New York: Harper and Row, 1986); Jack Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (New York: Cambridge University Press, 1998); Joanna Moncrieff, "An Investigation into the Precedents of Modern Drug Treatment in Psychiatry," *History of Psychiatry* 10, no. 4 (1999): 475-90; Lucy King, "The Best Possible Means of Benefiting the Incurable: Walter Bruetsch and the Malaria Treatment of Paresis," *Annals of Clinical Psychiatry* 12, no. 4 (2000): 197; Andrew Scull, "Focal Sepsis and Psychosis: The Career of Thomas Chivers Graves (1883-1964)," in *150 Years of British Psychiatry, Volume 2: The Aftermath*, ed. Hugh Freeman and German Berrios (London and New Jersey: Athlone, 1996), 517-36.

⁴⁸ Mark S. Micale, "The Psychiatric Body," in *Companion to Medicine in the Twentieth Century*, ed. Roger Cooter and John Pickstone (London: Routledge, 2000), 336.

2.1.6 Professionalisation

It is widely accepted, following the seminal work of Elliot Freidson (1970) and later, that of Harold Perkin (1989), that professional occupations, such as medicine and its specialisms, are characterised by a high degree of autonomy or self-regulation.⁴⁹ The process of professionalisation involves the development of specialist knowledge and of a system of education and qualification; protection against unqualified practitioners; the development of a code of ethics and the establishment of a controlling body for the profession.⁵⁰ The professionalisation of psychiatry and of mental nursing has attracted less attention than general medicine and nursing, but includes works by Isabelle von Bueltzingsloewen, Jan Goldstein, Ian Dowbiggin, J. Guyotat and Thierry Haustgen on the French psychiatric profession and by Andrew Scull, Hugh Freeman, Henry Rollin, Thomas Bewley and John Crammer on the professionalisation of British psychiatry.⁵¹ These works emphasise the varied social, political, cultural and medical circumstances that influenced the different trajectories of professionalisation of French and British psychiatry. The present study will add to this body of work through its use of the introduction of occupational therapy as an indicator of the level of professionalisation within psychiatry and mental nursing.

⁴⁹ Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York: Aldine, 1970); Harold Perkin, *The Rise of Professional Society: England since 1880* (Abingdon: Routledge, 1989).

⁵⁰ I. Waddington, "The Movement Towards the Professionalization of Medicine," *British Medical Journal* 301, no. 6754 (1990): 688.

See also: Gerald L. Geison, ed. *Professions and the French State, 1700-1900* (Philadelphia: University of Pennsylvania Press, 1984).

⁵¹ Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Chicago and London: University of Chicago Press, 2001); von Bueltzingsloewen, "Réalité Et Perspectives"; I. Dowbiggin, "French Psychiatry and the Search for a Professional Identity: The Société Médico-Psychologique 1840-1870," *Bulletin of the History of Medicine* 63, no. 3 (1989): 331-55; Thierry Haustgen, "Les Débuts De La Société Médico-Psychologique, Entre Philosophie Et Système Nerveux Central," *Annales médico-psychologiques* 170 (2012): 408-14; Andrew T. Scull, Nicholas Herve, and Charlotte MacKenzie, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, New Jersey: Princeton University Press, 1996); Hugh Freeman, "Psychiatry in Britain, c.1900," *History of Psychiatry* 21, no. 3 (2010): 312-24; Henry R. Rollin, "Psychiatry in Britain One Hundred Years Ago," *British Journal of Psychiatry*, no. 183 (2003): 292-98; Thomas Bewley, *Madness to Mental Illness* (London: The Royal College of Psychiatrists, 2008); John Crammer, "Training and Education in British Psychiatry 1770-1970," in *150 Years of British Psychiatry, Volume 2: The Aftermath*, ed. H.L. Freeman and G.E. Berrios (London: Athlone Press, 1996), 209-42; J. Guyotat, "La Formation Des Psychiatres En France," *Raison Présente* no. 83 (1987): 69-81.

The professional development of mental nursing has been addressed by Peter Nolan, Niall McCrae, Benoît Majerus, Geertje Boschma and Anne Borsay and Pamela Dale.⁵² This thesis contributes to these studies by highlighting the necessity of well-trained, well-educated nurses who were committed to their roles, for the successful introduction of occupational therapy even in mental hospitals that employed an occupational therapist. The development of the para-medical professions, such as occupational therapy, is addressed by Gerald Larkin.⁵³ Larkin emphasises the influence of social, technical and cultural forces, as well as the impact of developments within medicine, that gave rise to these professions.⁵⁴ This thesis supports his view and adds to it through consideration of the level of professionalism within the medical specialism as an influential factor in the emergence of a para-medical profession. The professional development of occupational therapy is discussed by historian of medicine John Hall and by OT practitioners Ann Wilcock (Britain), Catherine Paterson (Scotland) and social historian Jean-Pierre Goubert (France).⁵⁵ The ethos of OT is also covered in these works by OT practitioners which, as discussed in the following section, appears to be in opposition to modern working practices.

⁵² Peter Nolan, *A History of Mental Health Nursing* (London: Chapman and Hall, 1993); Niall McCrae and Peter Nolan, *The Story of Mental Nursing in British Mental Hospitals: Echoes from the Corridors* (London and New York: Routledge, 2016); Geertje Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1930* (Amsterdam: Amsterdam University Press, 2003); Anne Borsay and Pamela Dale, eds., *Mental Health Nursing: The Working Lives of Paid Carers in the Nineteenth and Twentieth Centuries* (Manchester: Manchester University Press, 2015); Benoît Majerus, "Surveiller, Punir Et Soigner? Pratiques Psychiatriques En Europe De L'ouest Du 19e Siècle Aux Années 1950," *Histoire, Médecine et Santé* no. 7 (2015): 51-62.

⁵³ Gerald Larkin, "The Emergence of Para-Medical Professions," in *Companion Encyclopedia of the History of Medicine*, ed. W. F. Bynum and R. Porter (London and New York: Routledge, 1994), 1329-40.

⁵⁴ *Ibid.*, 1331-3.

⁵⁵ John Hall, "From Work and Occupation to Occupational Therapy: The Policies of Professionalisation in English Mental Hospitals from 1919 to 1959," in *Work, Psychiatry and Society, C.1750-2015*, ed. Waltraud Ernst (Manchester: Manchester University Press, 2016), 314-33; Catherine F. Paterson, *Opportunities Not Prescriptions: The Development of Occupational Therapy in Scotland, 1900-1960* (Aberdeen: Aberdeen History of Medicine Publications, 2010); Ann Allart Wilcock, *Occupation for Health*, vol. 1 & 2 (London: British Association and College of Occupational Therapists, 2002); Goubert and Remondière, "Les Origines Historiques de L'Ergothérapie En France."

Part II: Productivity, Labour and Welfare

2.2.1 Productivity and Worker Satisfaction

The emergence of new ways of working in the early twentieth century indicate an increase in efforts to maximise productivity. The new production techniques were at odds with the essentially artisanal methods used in asylum workshops. Geoffrey Searle (2003) and Arthur McIvor (2001) highlight concerns regarding “national efficiency”, which rose to prominence between 1899 and 1914, and fear of losing Britain’s pre-eminent position as “the workshop of the world”. These concerns generated interest amongst the elites in the principles of scientific labour management emanating from the USA.⁵⁶ As McIvor observes, the scientific management philosophies of the American mechanical engineer Frederick Winslow Taylor (1856-1915) and automobile manufacturer Henry Ford (1863-1947) became increasingly popular in Britain and Europe from the 1900s onwards. “Taylorism”, as Taylor’s management ideas became known, encouraged managers to undertake a systematic evaluation of the labour processes involved in their business, with the aid of a stopwatch, and to maximise efficiency by subdividing tasks.⁵⁷ This led to a de-skilling of the workforce and a loss of worker discretion and autonomy.⁵⁸

World War I, as Roger Cooter and Steve Sturdy maintain (1998), acted as a catalyst for the development of these scientific management techniques to maximise productivity and efficiency both during the war, and during the post-war reconstruction period, when governments were keen to expedite economic recovery and prosperity.⁵⁹ Charles Bedaux (1886-1944), a French-born American management consultant, whose ideas were strongly influenced by those of Taylor, took Taylorism to extremes.⁶⁰ Bedaux encouraged the further

⁵⁶ G. R. Searle, "The Politics of National Efficiency and War, 1900-1918," in *A Companion to Early Twentieth-Century Britain*, ed. Chris Wrigley (Oxford: Blackwells, 2003), 56; Arthur McIvor, *A History of Work in Britain, 1880-1950* (Basingstoke: Palgrave, 2001), 44.

⁵⁷ McIvor, *A History of Work in Britain*, 54.

⁵⁸ *Ibid.*, 54-5.

⁵⁹ Steve Sturdy and Roger Cooter, "Science, Scientific Management and the Transformation of Medicine in Britain C.1870-1950," *History of Science* 36, no. 1 (1998): 421-6.

See also: Pierre-Cyrille Hautcoeur, "Was the Great War a Watershed? The Economics of World War I in France," in *The Economics of World War I*, ed. Stephen Broadberry and Mark Harrison (Cambridge: Cambridge University Press, 2005), 169-205; Jean-Charles Asselain, *Histoire Économique De La France Du 18e Siècle À Nos Jours: Depuis 1918*, vol. 2 (Paris: Points, 2011), 13-29.

⁶⁰ For a detailed account of Bedaux’s methods, see: Yves Levant and Marc Nikitin, "Charles Eugène Bedaux (1886-1944): 'Cost Killer' or Utopian Socialist?," *Accounting, Business and Financial History* 19, no. 2 (2009): 171-79.

deskilling of the workforce and even tighter controls over workers. These methods particularly affected the new assembly-line industries producing automobile parts,⁶¹ domestic appliances and other electrical goods, clothing and processed food.⁶² During the interwar period, as McIvor notes, Bedaux's methods were adopted by around 250 of Britain's largest manufacturing firms (including ICI, Morris Motors and Lyons).⁶³ Opposition from skilled workers and foremen impeded even wider adoption of his methods, however. Workers resented the loss of control, the close links between effort and earnings, and the stringent monitoring of performance.⁶⁴

There was opposition to scientific management methods by skilled workers in France too. Patrick Fridenson (1986) highlights the issue of boredom, fatigue and resentment of managerial control amongst French automobile factory workers, leading to absenteeism, slowing down or limiting production, and disrupting work schedules.⁶⁵ During the Depression, the French government intervened directly in the economy, introducing employment regulations and systems for industrial negotiation, and attempting to modernise production methods beyond the automotive industries.⁶⁶ The methods of Taylor and Bedaux, pioneered by Renault, Citroen and Peugeot, were promoted as a means of raising labour productivity and "rationalising" employment. Unpopular and perceived as a threat to traditional French working hierarchies, the imposition of such methods generated a wave of strike action in Paris in 1936.⁶⁷ The new methods struck at the very core of a French worker's identity, based on the established pattern of progress from journeyman to skilled *petit entrepreneur* and master of one's own destiny.⁶⁸

The new methods were clearly unpopular with both French and British workers. The deleterious effects of the division of labour and the "deskilling" of workers had already been highlighted by political economists Adam Smith in the eighteenth, and Karl Marx in the

⁶¹ The automobile industry grew rapidly in all four cities under consideration during the interwar period.

⁶² McIvor, *A History of Work in Britain*, 96.

⁶³ McIvor, *History of Work in Britain*, 58, 96.

⁶⁴ *Ibid.*, 97.

⁶⁵ Patrick Fridenson, "Automobile Workers in France and Their Work, 1914-1983," in *Work in France: Representations, Meaning, Organisation and Practice*, ed. Stephen Laurence Kaplan and Cynthia J. Koeppe (Ithaca and London: Cornell University Press, 1986), 514-64.

⁶⁶ Noel Whiteside, "Constructing Unemployment: Britain and France in Historical Perspective," *Social Policy and Administration* 48, no. 1 (2014): 77.

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

nineteenth centuries. In *The Wealth of Nations* (1776) Smith argues that a man spending all his time performing the same tasks had no need to “exert his understanding or exercise his invention” to solve problems, rendering him “stupid and ignorant”.⁶⁹ Karl Marx was also highly critical of the division of labour, which he claimed “attacks an individual at the very roots of his life” and could eventually lead to what he termed “industrial pathology”.⁷⁰ Describing factories as “mitigated jails”, he argued that the narrow, specialised functions associated with the division of labour reduced workers to a “fragment” of their former selves.⁷¹ Marx claimed that work under capitalism, divided up into meaningless repetitive tasks, was the opposite of *purposeful* activity – such as the work of the skilled watchmaker creating a complete watch – which Marx believed necessary for the “realisation of the full humanity of the individual”.⁷² While Smith and Marx were referring to the new factory conditions introduced during the first industrial revolution, their remarks are perhaps even more relevant to the very exacting methods of scientific management. The loss of autonomy and control, and the sheer monotony of the work, could be damaging to a worker’s mental health and self-esteem.

The notion of work satisfaction, as Waltraud Ernst (2016) highlights, is important in any study of patient work since its purpose was to promote well-being and a sense of agency.⁷³ On the one hand, mental hospitals were trying to equip recovering patients with work skills that would help them secure employment on discharge. To be truly rehabilitative, these skills needed to be up-to-date in order to prepare patients for the working environment outside hospital. On the other hand, reproducing working methods within hospital that were potentially harmful to mental health was counterproductive. These tensions are highlighted by Vicky Long (2016) in her analysis of the introduction of “industrial therapy” after World War II, but they are not discussed in the literature regarding patient work in the interwar period.⁷⁴ The American style of occupational therapy, based on teaching arts and

⁶⁹ Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations* (Ware, Herts.: Wordsworth Editions, 2012), 777-8.

⁷⁰ Karl Marx, *Capital* (Ware, Herts.: Wordsworth Editions, 2013), 253.

⁷¹ Edward Royce, *Classical Social Theory and Modern Society: Marx, Durkheim and Weber* (London and New York: Rowman and Littlefield, 2015), 135.

⁷² John Dupré and Regenia Gagnier, “A Brief History of Work,” *Journal of Economic Issues* 30, no. 2 (1996): 554.

⁷³ Ernst, “Therapy and Empowerment, Coercion and Punishment,” 3.

⁷⁴ Vicky Long, “Work Is Therapy? The Function of Employment in British Psychiatric Care after 1959,” in *Work, Psychiatry and Society, C.1750-2015*, ed. Waltraud Ernst, 334-50.

crafts to patients,⁷⁵ was focused on “purposeful activity” and provided an experience quite different to that of the factory floor. As Jennifer Laws (2011) emphasises, OT focused on the “therapeutic effects of quality workmanship” and stood in stark contrast to the monotonous and “degrading” practices of factory work.⁷⁶ This anomaly between therapy and rehabilitation is addressed by the present thesis.

New working methods that took account of their effect on the worker, as well as on the results achievable by management, were researched in Europe, independently of the Americans in the years before World War I. As Anson Rabinbach highlights, while Taylorism prioritised the interests of management and productivity, the European science of labour sought to transform work in the interests of both labour and management.⁷⁷ While Taylorist methods were researched by managers on the shop floor, the European science of labour was researched by doctors, psychologists and biologists in the laboratory. By rationalising the physiological and psychological performance of the labouring body, European scientists aimed to eliminate fatigue, overwork and wasteful motion, thereby improving the health, efficiency and productivity of workers.⁷⁸ The work in this area performed by the French psychiatrist Édouard Toulouse, who recognised the high social cost of the poor organisation of work, is analysed by Michel Huteau (2002) and William Schneider (1991).⁷⁹ As Schneider highlights, Toulouse believed that the whole question of work had to be studied scientifically, as he indicated in an article in *Le Journal* in 1905 entitled, “La Crise du travail”.⁸⁰ With colleagues Henri Piéron, Jean-Marie Lahy and Henri Laugier, Toulouse developed what he termed the “psychobiology of labour”, an inter-disciplinary application of scientific research to the practical problems of human work.⁸¹ The existing literature does

⁷⁵ The roots of OT in the Arts and Crafts Movement of the late nineteenth century are discussed in: Clare Hocking, “The Way We Were: Romantic Assumptions of Pioneering Occupational Therapists in the United Kingdom,” *British Journal of Occupational Therapy* 71, no. 4 (2008): 146-54.

⁷⁶ Laws, “Crackpots and Basket-Cases: A History of Therapeutic Work and Occupation,” 65-81.

⁷⁷ Anson Rabinbach, *The Human Motor: Energy, Fatigue and the Origins of Modernity* (Berkeley: University of California Press, 1992).

⁷⁸ *Ibid.*, 476.

⁷⁹ Michel Huteau, *Psychologie, Psychiatrie Et Société Sous La Troisième République. La Biocratie D'édouard Toulouse (1865-1947)* (Paris: L'Harmattan, 2002), 98-9.

⁸⁰ William H. Schneider, “The Scientific Study of Labour in Interwar France,” *French Historical Studies* 17, no. 2 (1991): 416-7.

⁸¹ *Ibid.*

not address whether the “psychobiology of labour” developed by Toulouse, who was CMO of the Villejuif Asylum from 1898-1922, impacted on patient work within an asylum setting.

2.2.2 The Effect of the Depression

In France, improving productivity was a priority during the immediate post-war period while the economy was struggling to recover. A period of rapid industrial expansion during the 1920s ended with the Great Depression, which once again put pressure on asylum and hospital finances. As James McMillan (1992) observes, although the impact of the Depression on France was minimal at the outset, its arrival was merely delayed.⁸² The crisis reached France in 1931 and its effects persisted until 1938, even after the upturn of the world economy in 1935. French economic activity during the interwar period peaked in 1929, but from 1931 France was engulfed by economic, political, social and moral malaise.⁸³ French overseas trade declined. After the devaluation of British sterling in 1931, French goods, particularly luxury items such as *haute couture*, were overpriced in the world market. Exports fell by 50% between 1929 and 1938. While between 1927 and 1931, the French balance of payments was in surplus by three milliard Francs, thereafter it was in debt by the same amount.⁸⁴ Production fell dramatically and by 1935, output had decreased by 20% compared with that of 1929.⁸⁵ Food and wine prices fell, much to the dismay of the peasant farmer, many of whom found themselves driven back to a subsistence economy. Agricultural incomes fell by 16% between 1930 and 1932, and by a further 17% between 1932 and 1934.⁸⁶ Discontent and agitation in the countryside were rife. Although France was not as badly affected as Britain, the unemployment figure of 5% was severe by French standards. How the French asylum system coped in such difficult economic circumstances, and how the situation affected patient work, is addressed by this thesis.

As Christopher Price (2007) observes, although the Depression had a profound impact on the British interwar economy, compared to its effect internationally, the British depression

⁸² James F. McMillan, *Twentieth-Century France: Politics and Society 1898-1991* (London: Arnold, 1992), 101.

⁸³ *Ibid.*, 102.

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*

was relatively “brief” and “shallow”.⁸⁷ Defined in terms of national income, the depression began in 1929 and ended in 1931, during which time GDP had contracted by just over 5%.⁸⁸ The already poor condition of Britain’s staple industries (steel, coal, shipbuilding and textiles) deteriorated rapidly. Export markets collapsed. While the resulting unemployment of over 3 million workers (or 22% of the national workforce) was heaviest in the north of England, Scotland, Wales and Northern Ireland, where these staple industries were located, the cost of unemployment was the responsibility of the whole nation.⁸⁹ Public finances were strained as tax revenues fell and the burden of unemployment benefit increased, putting additional pressure on hospital budgets.⁹⁰

2.2.3 Poverty, Unemployment and Welfare

The concept of unemployment or *chômage*, as Noel Whiteside (2014) maintains, entered public discourse in the late nineteenth century; by the early twentieth century debates on the problem of unemployment were taking place throughout Europe and the USA.⁹¹ Joblessness, regarded during much of the nineteenth century as the result of poor choices made by individuals who were expected to take responsibility for their fate, could no longer be explained by personal shortcomings. Unemployment began to be understood as an aspect of “the social question”, the term used to encompass a combination of political, economic and social factors requiring official attention.⁹² As attitudes focused on self-sufficiency and poverty as a form of moral failure were gradually eroded, the importance placed on patient work in English mental hospitals was also reduced. In England, as will be demonstrated in chapters five and six, the emphasis was on therapeutic occupation rather than the economic contribution made by patient work, or the rehabilitative role played by work around the hospital. In France, where attitudes (and legislation) took longer to change, the financial and rehabilitative rationale for patient work remained strong.

⁸⁷ Christopher Price, “Depression and Recovery,” in *Twentieth-Century Britain: Economic, Cultural and Social Change*, ed. Francesca Carnevali and Julie-Marie Strange (London and New York: Pearson, 2007), 145.

⁸⁸ Ibid.

⁸⁹ Ibid., 152.

⁹⁰ Ibid.

⁹¹ Whiteside, “Constructing Unemployment,” 68.

⁹² Ibid.

In nineteenth-century England, poor relief was provided by the New Poor Law of 1834, designed, according to Peter Bartlett (1999), to “root out and dismantle a culture of poverty, perceived in terms of immorality, intemperance and promiscuity, and replace it with a culture of self-help, respectability, sobriety and hard work”.⁹³ By the end of the nineteenth century, studies such as those of Charles Booth (1886) and Seebohm Rowntree (1899) and the application of statistics⁹⁴ to social analysis, revealed that misfortune (such as the occurrence of industrial accidents, or loss of work) often had little to do with individual fault.⁹⁵ As Lees (1998) emphasises, during the early 1900s, attitudes towards the poor were changing, indicated by growing calls for the reform of the English Poor Law and for increased state intervention.⁹⁶

Such intervention began, as Royle (2012) observes, with legislation introduced between 1905 and 1914 aimed at attacking the causes of poverty, namely old age, sickness, death of the breadwinner, low wages and unemployment.⁹⁷ Measures to relieve unemployment included the 1905 Unemployed Workmen’s Act, empowering local authorities to establish labour exchanges and labour colonies, and to create work for the unemployed. The Labour Exchanges Act of 1909 created a national network through which the unemployed could search for work. The National Insurance Act of 1911 provided compulsory, contributory insurance for most employed individuals against the financial consequences of sickness, disablement, maternity, and short-term unemployment.⁹⁸ These measures clearly demonstrate an increased state responsibility for citizens’ welfare, and an acknowledgement that unemployment and other social misfortunes were not the “fault” of individuals. The poor were no longer expected to be entirely self-sufficient. While late nineteenth-century psychiatric texts made frequent references to the “creation of useful members of society” who could earn their own living after discharge, as Sarah Chaney

⁹³ Peter Bartlett, "The Asylum and the Poor Law: The Productive Alliance," in *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective*, ed. Joseph Melling and Bill Forsythe (London and New York: Routledge, 1999), 53.

⁹⁴ Between 1890 and 1910 several of the major techniques of mathematical statistics developed by Karl Pearson and others were used to calculate causal relationships and applied to social phenomena such as pauperism. See: Lynn Hollen Lees, *The Solidarities of Strangers: The English Poor Laws and the People, 1700-1948* (Cambridge: Cambridge University Press, 1998), 312-7.

⁹⁵ Philip Nord, "The Welfare State in France, 1870-1914," *French Historical Studies* 18, no. 3 (1994): 824.

⁹⁶ Lees, *The Solidarities of Strangers*, 310.

⁹⁷ Edward Royle, *Modern Britain: A Social History 1750-2011*, Third ed. (London and New York: Bloomsbury, 2012), 235.

⁹⁸ Ibid.

(2016) observes, this type of rhetoric was far less common after World War I, suggesting that the development of self-sufficiency amongst patients was no longer a priority for mental hospitals.⁹⁹ The literature does not explore the relationship between this change in the rhetoric and the actual practice of patient work, a lacuna addressed by this study.

The role of the state was also debated in *fin-de-siècle* France, by defenders of *laissez-faire* liberalism and those who favoured state provision of welfare, as Philip Dutton (2002) outlines.¹⁰⁰ Between 1890 and 1910, the budget for public health and assistance doubled, but widespread social reform legislation had to wait until the late 1920s. Until then, “initiative and prudence” were supposed to protect the working man and his family from the consequences of accidents, illness, disability, old age and unemployment.¹⁰¹ Between 1928 and 1932, social insurance laws covering illness, disability, maternity, old age and short-term unemployment, providing similar protection to the British National Insurance Act of 1911, were introduced.¹⁰² Further welfare measures were introduced under Léon Blum’s Popular Front government (1936-38).¹⁰³

In England after World War I, Royle maintains that social welfare policy was shaped by the need to limit public expenditure and cope with the rise in unemployment.¹⁰⁴ The poor law broke down under the strain, leading the government to disband the poor law unions.¹⁰⁵ According to the terms of the Local Government Act 1929 the responsibilities of the poor law institutions were transferred to county and county borough councils, who created new Public Assistance Institutions (often using former workhouse buildings) and Committees.¹⁰⁶ Mass unemployment, that peaked during the Great Depression, resulted in a series of legislative changes extending welfare benefits, including the establishment of an Unemployment Assistance Board in 1934.¹⁰⁷ By 1937, care for the able-bodied had moved away from the Public Assistance Committees. The link between the pejorative poor laws and

⁹⁹ Chaney, "Useful Members of Society or Motiveless Malingerers?," 282.

¹⁰⁰ Paul V. Dutton, *Origins of the French Welfare State: The Struggle for Social Reform in France, 1914-1947* (Cambridge: Cambridge University Press, 2002), 5.

¹⁰¹ Ibid., 5-6.

¹⁰² Ibid., 97.

¹⁰³ Ibid., 183.

¹⁰⁴ Royle, *Modern Britain*, 239.

¹⁰⁵ Ibid.

¹⁰⁶ Lees, *The Solidarities of Strangers*, 7, 331.

¹⁰⁷ Royle, *Modern Britain*, 239-40.

the unemployed was finally broken as assistance for the poor was provided by more modern welfare measures.¹⁰⁸

Attitudes towards self-sufficiency and work, which changed at different paces in France and England, appeared to influence the degree of importance attached to the rehabilitative value of patient work in French and English mental hospitals. This is not explored by the existing literature. Attitudes in England changed earlier than they did in France (as indicated by the later introduction of welfare measures). English patients would not be left completely destitute if they were unable to find work on leaving hospital, as they would in France until the early 1930s, which, in one sense, freed English psychiatrists to focus on therapy (such as occupational therapy) rather than rehabilitation. That said, the higher level of unemployment in England may have made the acquisition of work skills even more important for patients leaving hospital and trying to find work in a difficult economic climate. Doctors were aware that joblessness created anxiety and stress that could lead to a relapse of symptoms and readmission to hospital. These conundrums are explored in this thesis.

2.2.4 Conclusion

The literature has raised questions over whether asylums fulfilled a social control function, seeking to remodel the mentally ill to conform to contemporary notions of the productive citizen, or whether they were benign institutions where the emphasis was on care and where patient work was designed to benefit patients rather than institutions. Authors focusing on the end of the nineteenth century emphasised anxiety regarding degeneration, the rise in levels of poverty and social deviance, declining national efficiency and, in France, declining birth rates. The inclusion of all forms of social deviance, not simply mental disorder, within the purview of psychiatry was highlighted. As asylums became overcrowded with incurable cases, and as the theory of hereditary degeneration was widely accepted as the cause of mental disorder, increasing levels of asylum discipline were observed, with patient work perceived as a means of making patients more manageable and of offsetting costs rather than providing therapy. The literature lacks analysis on the changing rationales

¹⁰⁸ Ibid., 332.

for patient occupation during the interwar period, a gap that this thesis seeks to fill, and, through a comparison between England and France, to explore the reasons for a divergence in the practice of work therapy during this period.

The treatment of war neuroses during World War I led to a greater interest in psychotherapy and treatment regimes involving work, although this was less apparent in France. It seems, although this is not made explicit in the existing literature, that the closer alignment between neurology and psychiatry in France led to a preference for neurological treatment methods during the war that did not embrace work and occupation. Psychiatrists offering psychotherapy and occupation to British soldiers, on the other hand, found that occupation was a useful means of re-education, which, it is argued in chapter three, revived enthusiasm for therapeutic occupation after the war.

Historians conducting research into somatic treatments emphasised psychiatrists' awareness of the weakness of their therapeutic arsenal in the early twentieth century; their anxiety to find effective treatments; and their keenness to demonstrate that psychiatry was worthy of respect within the medical profession and worthy of trust by the public. The pressure to find a medical cure that would secure psychiatry's place as a scientific discipline contributed to the premature adoption, particularly in France, of radical new medical therapies without due regard for the patient's long-term health or wellbeing. How patient work was used in conjunction with these radical therapies, and whether the prescription of patient work or occupational therapy was helpful to the psychiatrists' quest for professional recognition is investigated in the following study.

The literature regarding the new ways of working, based on the principles of scientific management, draws attention to the contemporary pre-occupation with productivity. It also highlights an interesting paradox between these new working practices, which led to a "deskilling" of the workforce and a loss of control of the production process, and the American style of occupational therapy, which focused on teaching patients to make unique hand-crafted objects, using traditional techniques, that were the antithesis of mass production. How this was rationalised with preparing patients for the labour market is addressed by this thesis, but one explanation may lie in the changing attitudes towards unemployment and welfare, highlighted in the literature. The development of new ideas regarding occupational therapy (OT), both the American-style of OT based on arts and crafts

and the German-style “more active therapy” which was oriented towards work within the hospital, is addressed in chapter four. This analysis follows an exploration of the psychiatric context in which these new ideas were received in France and England.

Chapter 3:

From Alienism to Psychiatry in French and English Institutions

3.0 Introduction

The evolution of patient occupation from routine work around the hospital to carefully supervised occupational therapy depended on the establishment of psychiatry as an autonomous discipline. Professionalisation depended on the development of independent specialist training, qualifications and research initiatives. Receptivity to using occupation therapeutically required psychiatrists to leave behind the purely organicist approach associated with hereditary degeneration and a custodial model of care known as “alienism”, and free themselves from an association with neurology which was based on physiology. For psychiatrists adhering to a purely organicist interpretation of mental disorder, patient work remained a useful distraction (and a useful source of labour) but was not considered curative.¹ Psychiatrists taking a more holistic approach,² based on the view that mental disorder could also be linked to social factors and problems of adaptation to the environment (as well as physiological factors), found psychotherapy and re-educative techniques, such as OT, an essential aspect of their active treatment regimes. A holistic approach, which was characteristic of American psychiatry and associated with the Mental Hygiene Movement, was most unusual in France (and practically unknown outside Paris), where the majority of psychiatrists were organicists.

The comparative evidence gathered by this thesis (analysed in chapters five and six) suggests that the successful introduction of OT required not only the professionalisation of psychiatry in terms of training and research and an ideological shift from an organicist to a more holistic perspective, but was also linked to a variety of factors related to infrastructure and resources, which differed according to the country under study. In terms of infrastructure, these factors included the extent to which legislation and admissions policies encouraged a focus on acute cases and active treatment; medical directors were put in sole charge of the institution; outpatient facilities were provided; and the use of psychiatric social workers was introduced. In terms of resources, they related to adequate staff

¹ See chapter 1 for definition of an organicist interpretation of mental disorder, footnote 3.

² See chapter 1 for definition of a holistic approach, *ibid*.

numbers, and properly equipped hospitals that were free from overcrowding, on the one hand, and freedom from having to rely on the financial contribution made by existing systems of patient work, on the other hand.

Part I: Ideological Shifts

3.1.1 Psychiatry in 1900

At the beginning of the twentieth century, the influence of hereditary degeneration led to a focus on custody and care, rather than treatment, within public asylums.³ The hereditary model of mental disorder, developed by the French Bénédict-Augustin Morel in 1857, held that mental illness was directly inheritable and therefore incurable. This model was widely adopted by British and French psychiatrists, including Henry Maudsley (1835-1918) in England and Valentin Magnan (1835-1916) in France, for whom it provided an explanation for psychiatry's therapeutic impotence.⁴ The optimism associated with the emergence of moral therapy in the early nineteenth century, and the idea that care in a well-ordered institution was itself therapeutic, gave way in the second half of the nineteenth century to pessimism regarding the curability of insanity. Psychiatry in both France and England compared unfavourably with the rapid advances made in other areas of medicine, such as neurology, and psychiatrists were anxious to assert their professional status.⁵ Their woeful track record of cure caused practitioners to be regarded by the rest of the medical profession as the poor cousins, or "Cinderellas", of medicine.⁶ Psychiatrists "desperately wanted to be part of the strengthening trend towards medicine-as-science", but in 1900 there were no more effective cures than there had been a hundred years previously, and their role was closer to that of custodian than doctor.⁷

Asylum medicine, associated with this custodial role, was known as "alienism". It stood in stark contrast with the research-based, treatment-orientated methods of large hospitals.

³ Joan Busfield, "Mental Illness," in *Companion to Medicine in the Twentieth Century*, ed. Roger Cooter and John Pickstone (London and New York: Routledge, 2003), 644.

⁴ Freeman, "Psychiatry in Britain," 328.

⁵ MacKenzie, *Psychiatry for the Rich*, 210.

⁶ Diana Gittins, *Madness in Its Place: Narratives of Severalls Hospital 1913-1997* (London and New York: Routledge, 2006), 3.

⁷ Ibid.

Alienists, as psychiatrists were known until the early twentieth century, adhered to an organicist interpretation of mental illness, based on the theory of hereditary degeneration. The latter had created a sharp division between what was considered “normal” and “pathological”. Either an individual was normal or insane. If insane, the causes of their insanity were presumed to be physiological and incurable. Patients were routinely managed rather than actively treated.⁸ Work, from being a “cornerstone” of moral therapy prescribed according to patient need, simply became part of the daily asylum routine, organised to supplement the smooth-running of the institution, and to distract calm, chronic patients. Convalescent patients also worked, in preparation for life outside the institution, but work was not perceived as curative.

The emergence of psychological theories during the late nineteenth and early twentieth centuries led to a questioning of such a binary conception of mental disorder.⁹ These theories suggested that mental disorder might have a psychological, rather than a physiological origin, or result from a combination of factors. No longer was an individual simply sane (without physiological lesions) or insane (exhibiting a physiological problem associated with the brain or central nervous system). Psychology was based on behaviour which was less easy to classify as “sane” or “insane”. Varying degrees of mental disorder placed an individual somewhere on a spectrum of normality and pathology.¹⁰ This erosion of the traditional boundary between normality and pathology was sometimes referred to as the “continuity” of mental disorder.¹¹ The gradual disappearance of the term “alienism” marked the end of asylum medicine’s isolation from the rest of medicine and a belief in both the curability of mental disorder and its “continuity”.¹² The applicability of the term “alienism” receded at different times in different places. Provincial asylums, for example, continued to be managed by “alienists” for much longer than those in large cities. For the purpose of this thesis, the term is a useful indicator of the level of professionalisation of psychiatry, which in turn is linked to the approach towards patient work taken by asylum doctors. Those who remained in the “alienist” mould (such as the CMO of the ADLS during the 1920s) were more likely to continue regarding patient work as part of the routinised

⁸ Ibid.

⁹ Postel and Quétel, *Nouvelle Histoire De La Psychiatrie*, 342.

¹⁰ Hayward, *The Transformation of the Psyche*, 71.

¹¹ Ibid.

¹² Postel and Quétel, *Nouvelle Histoire De La Psychiatrie*, 342.

system of asylum management that offered a useful distraction for calm, chronic and the few convalescent patients who made a recovery. Psychiatrists, on the other hand, who believed in the curability of mental illness, were more open to new therapies, such as occupational therapy and the new biological treatments that emerged in the 1920s and 1930s. Those who accepted that mental disorder might have a psychological origin were more likely to adopt psychotherapy and occupational therapy, than psychiatrists who interpreted mental disorder as a purely neurological condition.

3.1.2 The Alignment of French Psychiatry with Neurology

In Britain, neurology was an entirely separate discipline, with a centre of excellence in London at the National Hospital, Queen Square, which opened in 1860.¹³ British neurologists did not tend to become involved in asylum medicine and, unlike in France, neuropsychiatry did not develop as a combined major specialty.¹⁴ In contrast, French asylum doctors sought to boost their credibility by closely aligning themselves with neurology, the leading medical specialty in *fin-de-siècle* France.¹⁵ Neurologists, benefiting from advances in microscopy, improved laboratory techniques and experimental methods, had enhanced their understanding of neuroanatomy and neurological disease during the latter half of the nineteenth century.

Alienists, on the other hand, were unable to demonstrate the value of asylum medicine, either by identifying the physiological causes of mental disorder, or by effecting cures. Asylum medicine had therefore suffered frequent attacks from the press after 1860, when censorship laws were relaxed.¹⁶ Journalists cited therapeutic failure, inappropriate sequestration and the neglect of patients. Morale among alienists had plummeted and asylums fell into disrepair. Consequently, alienists were keen to attach themselves to the more prestigious, scientifically advanced specialism of neurology.¹⁷ Alienism and neurology

¹³ Freeman, "Psychiatry in Britain," 318.

¹⁴ *Ibid.*, 317.

¹⁵ See: Toby Gelfand, "Neurologist or Psychiatrist? The Public and Private Domains of Jean-Martin Charcot," *Journal of the History of the Behavioural Sciences* 46, no. 3 (2000): 215-29.

¹⁶ G.M. Thomas, *Treating the Trauma of the Great War: Soldiers, Civilians and Psychiatrists in France, 1914-1940* (Baton Rouge: Louisiana State University Press, 2009), 30.

¹⁷ *Ibid.*, 31.

overlapped in many ways; both interpreted mental disorder from an organicist perspective; it was possible for doctors to switch from one to the other with ease as professional qualifications were yet to be established in either specialism; and many of the alienists who worked in the Seine asylums had studied neurology at the Salpêtrière before taking up their asylum posts. Until the 1950s, the Chairs of Mental Disorder at the Paris Faculty of Medicine,¹⁸ such as Gilbert Ballet (1853-1916), were all trained neurologists.¹⁹

From 1894, neurologists were included in the annual alienists' conference, which became known as the *Congrès des aliénistes et neurologistes*.²⁰ Gilbert Ballet, who became Chair of Mental Disorder in 1909, was instrumental in developing the alliance between neurology and asylum medicine. Ballet founded a new journal, *L'Encéphale* (meaning "brain"), in 1906, with the aim of overcoming psychiatry's isolation from the rest of medicine and highlighting the many commonalities between neurology and the treatment of mental illness.²¹

Neurology's high status in France was due to the work of Jean-Martin Charcot (1825-93), the first Professor of Clinical Diseases of the Nervous System at the University of Paris (from 1882). Practising at the Salpêtrière hospital, Charcot pioneered a systematic approach to the clinical analysis of many neurological conditions, but was most famous for his research into hysteria, one of the so-called 'functional nervous disorders'. Charcot adhered to the theory of degeneration prevalent in the late nineteenth century; he attributed hysteria to the psychical effects of traumatic events on a degenerate individual.²² In other words, the underlying cause of hysteria was physiological, linked to a weakness of the central nervous system, while the symptoms were psychological, triggered by a traumatic experience.²³ No physical lesion could be found to indicate a physiological weakness, however, prompting consideration of alternative, non-organic conceptualisations of the condition by the next generation of neurologists, including Joseph Babinski (1857-1932).

¹⁸ The Faculty Clinic of Mental Disorder was based at Ste Anne's.

¹⁹ Thomas, *Treating the Trauma of the Great War: Soldiers, Civilians and Psychiatrists in France, 1914-1940*, 31.

²⁰ Postel and Quézel, *Nouvelle Histoire De La Psychiatrie*, 341.

²¹ Ibid.

²² Hayward, *The Transformation of the Psyche*, 17.

²³ Ibid.

3.1.3 The Emergence of More Psychological Approaches to Psychiatry

Questioning of rigidly organicist interpretations of mental disorder was also stimulated by developments in psychology during the last quarter of the nineteenth century. The famous German psychiatrist Emil Kraepelin (1856-1926) adopted a multiple approach to psychiatry that incorporated not only neurology and brain anatomy, but also experimental psychology and a thorough investigation of the patient's life history.²⁴ The Swiss psychiatrist Eugen Bleuler (1857-1939), who developed new theories regarding schizophrenia, also sought to introduce greater psychological understanding in the treatment of mental patients between 1890 and 1900.²⁵ As medical director of the Rheinau, and later the Burgholzli Mental Hospitals, Bleuler developed psychological treatment regimes that included occupation, which he considered essential to a patient's health. Bleuler pioneered the approach that would later be developed by the American psychiatrist, Adolf Meyer.²⁶ Psychodynamic theories were most famously developed by the Viennese neurologist, Sigmund Freud (1856-1939) and the Swiss psychiatrist Carl Jung (1875-1961), who had worked as Bleuler's assistant. Less well-known were the psychoanalytic theories of French psychologist Pierre Janet (1859-1947). In fact, Janet developed the concept of psychological analysis seven years before Freud, who coined the phrase "psychoanalysis" in 1896.²⁷

Psychological interpretations of mental disorder were therefore in circulation on the continent, and in France and Britain, before World War I. In addition, experimental psychology laboratories were established in Paris (1889) and Cambridge (1897); national psychological societies were founded in both countries in 1901; and journals dedicated to psychology in 1904. While the evolution of psychology appeared to follow similar trajectories in France and Britain, a significant difference lay in the pre-war familiarity with, and interest in, psychoanalysis. Freud's theories were in circulation in Britain well before 1914, whereas in France they were almost unknown until after World War I. The British psychiatrist David Eder read a paper on Freud's methods to the British Medical Association in 1911; Freud's *Papers on Psycho-Analysis* were published in Britain in 1912 and the London

²⁴ Ellenberger, *The Discovery of the Unconscious*, 284.

²⁵ Ibid., 288.

²⁶ Ibid.

²⁷ Michael Fitzgerald, "Why Did Sigmund Freud Refuse to See Pierre Janet? Origins of Psychoanalysis: Janet, Freud or Both?," *History of Psychiatry* 28 (2017): 358.

Society of Psychoanalysis was founded in 1913.²⁸ Bernard Hart (1879-1966), who, before World War I worked at the Long Grove Asylum with Edward Mapother, published *The Psychology of Insanity* in 1912 in which reference was made to the work of Freud, Jung and Janet.²⁹

Despite the work of the French psychologist, Pierre Janet, who developed a similar psychodynamic approach to that of Freud, psychoanalysis failed to attract significant attention amongst French psychiatrists before the war. This can be explained in terms of their widely held and firmly entrenched organicist views. Psychological approaches to mental disorder did not impinge upon asylum medicine in France before World War I, whereas in Britain, notably at the new Long Grove Asylum in Epsom, Surrey (founded in 1907), psychiatrists responded more favourably.³⁰ A psychodynamic approach was influential in the development of treatment for traumatised British, but not French, soldiers during World War I. This would have implications not only for the introduction of patient work, but for the future development of psychiatry in each country.

3.1.4 The influence of World War I on French and English Approaches to Psychiatry

During World War I, approaches to treating soldiers suffering from war neuroses (the term “shell-shock” was only used in England) reflected the different psychiatric traditions of each of the combatant countries.³¹ They also depended on the physicians’ previous training and social networks.³² Variations between the tradition, training and social networks of French and British physicians led to different emphases on the use of occupation as a treatment for war neuroses in France and Britain. A greater emphasis on neurological approaches (which did not involve occupation) in France and a stronger emphasis on psychotherapy and re-

²⁸ Roy Porter, "Two Cheers for Psychiatry! The Social History of Mental Disorder in Twentieth-Century Britain," in *150 Years of British Psychiatry*, ed. Hugh Freeman and G.E. Berrios (London and Atlantic Highlands: Athlone, 1996), 388-9.

²⁹ Bernard Hart, *The Psychology of Insanity* (Cambridge: Cambridge University Press, 1912). A fourth edition of the work was published in 1930.

³⁰ Philip Kuhn, *Psychoanalysis in Britain 1893-1913: Histories and Historiography* (New York: Lexington Books, 2016), 272.

³¹ L. Crocq, "La Psychiatrie De La Première Guerre Mondiale. Tableaux Cliniques, Options Pathogéniques, Doctrine Thérapeutiques," *Annales Médico-psychologiques* no. 163 (2005): 285.

³² Feudtner, "'Minds the Dead Have Ravished'," 388.

education (which did involve occupation) in Britain appeared to affect the readiness of psychiatrists in each country to adopt new methods of occupying patients after the war.

3.1.5 Treatment of War Neuroses by the British

Conventional historical accounts hold that before World War I, all British psychiatrists were “physicalists” who regarded war neurosis as a “functional nervous disease”, the underlying cause of which was physiological and linked to notions of hereditary degeneration, and that by the end of the conflict, psychiatrists’ approach had become more psychological, incorporating the methodology of Freud and psychoanalysis.³³ This interpretation rightly emphasises the role of the war in boosting the subsequent spread of depth psychology, but oversimplifies the situation.³⁴ Partly physical and partly psychological diagnoses of traumatic hysteria and neurasthenia were widespread before 1914.³⁵ Physicians who were known to have a strong physical, neurological view of war neurosis, such as Frederick Mott, also recognised the psychological aspects of the condition, while some psychologists, such as William McDougall, linked mental disorders with underlying physiological issues. There was no “crisp dividing line” between the physicalists and the psychologists; the reality was more nuanced.³⁶ There were also variations in the types of treatment that constituted “psychological” treatment, which included techniques of persuasion and psychoanalysis. Feudtner writes about the British experience, but his arguments could equally apply to France.

The different training and networks of those involved in treating shell-shocked soldiers led to different approaches. Historian Eric Leed identified two different techniques in the British treatment of shell-shock, “disciplinary” and “analytic”, which were “rooted in two different conceptual frameworks and visions of human nature”.³⁷ The disciplinary method, or “quick cure” was the preferred method in the French military. It was based on a ‘moral’ view of war neurosis as a form of malingering. This method was associated with the neurological National Hospital at Queen Square where a specialist unit had been opened for severe cases of shell-shock. The treatment comprised a mix of high pressure techniques of persuasion;

³³ Ibid., 413 footnote 37; 386.

³⁴ Ibid., 386.

³⁵ Ibid., 387.

³⁶ Ibid., 388.

³⁷ Leese, *Shell Shock: Traumatic Neurosis*, 73.

shouted commands were accompanied by the use of strong, painful electric shocks (faradisation), icy showers and isolation.³⁸ The analytic method, associated with psychologists based at the Red Cross Hospital, Maghull, including W.H.R. Rivers, T.H. Pear and William McDougall, won the “grudging support” of the military authorities towards the end of war, and the Maghull was given responsibility for training military psychiatrists.³⁹ This method, which included re-education and psychotherapy, involved paying close attention to the whole patient (that is, their state of mind and not just their neurological symptoms).⁴⁰

The emphasis placed upon the re-education of the patient, a key aspect of which was the prescription of work and occupation, contributed to the greater interest shown in therapeutic occupation in the UK during the interwar period. The emphasis on occupation is revealed in a number of English publications produced during or just after the war. Elliot Smith and T.H. Pear’s *Shell Shock and its Lessons* (1917), for example, advocated therapeutic work for the shell-shocked patient to prevent him from “dwelling upon his subjective troubles”.⁴¹ A “suitable occupation” should be identified comprising “useful work” to stop the patient from feeling that he was a burden, reflecting contemporary notions of usefulness, efficiency and duty. The work should be interesting and occupy the patient’s mind, not just his body, and combined with attempts to identify the root cause of his trouble through psychotherapy.⁴²

A report by American psychiatrist, T.W. Salmon, who visited British treatment centres in France before the US entered the war, believed that “re-education by physical means is a valuable adjunct to treatment” and that this was best achieved by occupation.⁴³ While the British facilities for treatment were quite limited, the Americans introduced a range of clinical interventions, which included the provision of occupational therapy workshops.⁴⁴ Activities could be conducted in bed (such as basket-making, net-making, polishing and

³⁸ Ibid., 74.

³⁹ Jones and Wessely, *Shell Shock to PTSD*, 33.

⁴⁰ Leese, *Shell Shock: Traumatic Neurosis*, 81-4.

⁴¹ G. Elliot Smith and T.H. Pear, *Shell Shock and its Lessons*, Second Edition (Manchester: Manchester University Press, 1917), 51.

⁴² Ibid., 51-2.

⁴³ Thomas W. Salmon, *The Care and Treatment of Mental Diseases and War Neuroses (“shell-shock”) in the British Army* (New York: War Work Committee of the National Committee for Mental Hygiene, 1917), 39.

⁴⁴ Jones and Wessely, *Shell Shock to PTSD*, 32. [OT had evolved as a profession in the USA just before the Americans’ entry into the war in 1917.]

sand-papering), indoors (such as carpentry, wood carving, metal work, printing, book-binding and cigarette making) or outdoors (including farming, gardening, animal care and building work).⁴⁵ Salmon emphasised that “shell-shock” was a disorder of “will” as well as function and that “progressive achievement” was the only means by which “manhood and self-respect” could be restored.⁴⁶ Patients were encouraged to undertake physical tasks such as the cultivation of farmland, wood cutting and road construction, and art therapy.⁴⁷

British physician Millais Culpin, who had treated British troops in France in treatment centres established by the British military, also emphasised the value of work for shell-shocked patients in *The Psychoneuroses of War and Peace* (1920). Work and hobbies formed part of a programme of psychotherapy and re-education in which “all methods converge[d] and overlap[ped] in order to make the patient efficient again and to enable him to cope with himself and his environment”. Doctors sought to re-establish patients’ self-confidence, which was usually “painfully lacking”, by assigning chores and small projects that fostered a sense of achievement.⁴⁸ Work helped the patient feel that he was capable of “taking part in the world again” and provided a “useful gauge of his progress towards active citizenship”.⁴⁹ The War Office Committee agreed, maintaining that at the re-education stage of treatment, “the patient should be occupied consistently and not allowed to slip back into unprofitable habits by neglect or lack of mental diversion”.⁵⁰ At the Maudsley Hospital,⁵¹ under the direction of Frederick Mott, “an atmosphere of cure” was emphasised through “purposeful activity”. Occupational therapy and social activities were encouraged; soldiers grew vegetables in the hospital grounds and constructed a poultry house to provide a supply of fresh produce. Patients were taught carpentry and woodwork in a large, fully equipped workshop. Mott donated a piano and advocated choral singing as an “uplifting mental diversion” which he believed would foster “that sense of wellbeing so essential for

⁴⁵ Salmon, *Care and Treatment*, 40.

⁴⁶ Ibid.

⁴⁷ Jones and Wessely, *Shell Shock to PTSD*, 32.

⁴⁸ Feudtner, “‘Minds the Dead Have Ravished’,” 401.

⁴⁹ Ibid.

⁵⁰ Report of the War Office Committee Enquiry into “Shell-shock” (HMSO: London, 1922), 130.

⁵¹ The hospital was loaned by the Royal Army Medical Corps for the duration of the war, and from 1919-20, by the Ministry of Pensions, for the treatment of servicemen and ex-servicemen suffering from neurasthenia.

mental and bodily recuperation".⁵² These re-educative methods involving occupation were rare in French military psychiatry.

3.1.6 Treatment of War Neuroses by the French

The French Army's *Service de Santé* equated war neuroses with hysteria, a condition with a high profile in France. The authorities regarded the incidence of such disorders as highly contagious, posing a threat to the morale of the army that needed to be contained.⁵³ The "disciplinary" approach to treatment, associated with neurology (the dominant medical specialty in France and with which psychiatry had attempted to align itself) was preferred by the French military authorities. Military neuropsychiatric treatment centres were established in the main cities and run by neurologists. In Paris, for example, neurologists Jules Déjerine and Pierre Marie assumed responsibility for the military neurological department at the Salpêtrière; Joseph Babinski and Jules Froment took over the military unit at the Pitié; Gilbert Ballet at the Maison Blanche and Achille Souques at the Paul-Brousse Hospital.⁵⁴ Neuropsychiatric centres were also established near the Front, overseen by neurologist Gustave Roussy.

The disciplinary approach, similar to that adopted at the English neurological hospital at Queen Square, was championed by neurologist Joseph Babinski, Charcot's former pupil. It was this approach that came to dominate French treatment of war neuroses.⁵⁵ Babinski's methods were "virile and correctional", sometimes involving the use of electricity to produce intense pain. This technique, which became known as *torpillage*, was controversial and some soldiers refused treatment.⁵⁶ These disciplinary methods did not treat the underlying psychological causes of the trauma, but were effective in removing, in the short-term at least, the physical symptoms of war trauma, such as mutism or an inability to walk. Recidivism was common, however. It has been suggested that in countries where the fighting was on their own territory, such as France, firm physical methods of treatment predominated, while elsewhere (such as Britain) patient management was focused on

⁵² Edgar Jones, "An Atmosphere of Cure: Frederick Mott, Shell Shock and the Maudsley," *History of Psychiatry* 25, no. 4 (2014).

⁵³ Roudebush, "A Battle of Nerves," 254.

⁵⁴ Bogousslavsky and Tatu, "French Neuropsychiatry," 147.

⁵⁵ See: Joseph Babinski, *Hystérie-pithiatisme et troubles nerveux d'ordre réflexe* (Paris: Masson, 1917).

⁵⁶ Bogousslavsky and Tatu, "French Neuropsychiatry," 149.

longer-term psychological methods.⁵⁷ French physical methods of persuasion, whether or not they involved the more extreme measures of *torpillage*, were based on a medical-military attitude that sought the rapid return of soldiers to the Front to defend French territory.⁵⁸ Physical therapies were preferred in France, although some doctors did opt for more psychological methods.

There was one French military treatment centre where work was used therapeutically. At the Montpellier centre, Dr Villaret developed a programme of “professional re-education” involving a form of occupational therapy (*ergothérapie*).⁵⁹ Agricultural work, artisanal activities such as metalwork, leatherwork, woodwork and upholstery formed part of a programme that included training in typing, accounting and languages. Recovering patients assisted the nurses with training new patients.⁶⁰ The fact that Dr Villaret’s programme was unique in France at that time and was not seen in French hospitals until after World War II, highlights the very different approach to occupation and its evaluation as a therapy by French psychiatrists.

By the end of the war, British servicemen suffering from war neurosis were more likely to receive holistic treatment that focused on their psychological condition as well as their physical symptoms. The psychodynamic treatment offered at the Maghull was perceived as the most effective, long-term method of treatment.⁶¹ The British recognised the value of in-depth psychotherapy coupled with re-educative techniques involving work and OT. This was reinforced by endorsement from the Americans, who established sophisticated occupational therapy workshops within their treatment centres near the Front. In France, the disciplinary or quick cure, based on physical treatment methods, was preferred. These did not incorporate work therapy or OT and did not deal with the underlying psychological causes of the traumatic response. The different approaches to dealing with war neuroses by French and English psychiatrists emphasised the different psychiatric traditions of each country; these traditions led to divergent responses to new theories of therapeutic occupation emerging after World War I.

⁵⁷ Ibid., 150.

⁵⁸ Ibid.

⁵⁹ Guillemain and Tison, *Du Front À L'asile*, 322.

⁶⁰ Ibid.

⁶¹ The “quick cure” resulted in many cases of recidivism.

3.1.7 Psychiatry after World War I

The war highlighted the need for services where mildly troubled former soldiers and traumatised civilians could be treated without the threat of internment in an asylum.⁶² The psychological effect of the war on civilians was particularly noticeable in France, where the privations of war had taken their toll. The cure of these individuals was essential to revitalise the French nation and reformers, such as Édouard Toulouse, called for the establishment of new, medicalised psychiatric facilities.⁶³ The post war period in both France and England saw the introduction of social hygiene measures to improve the mental and physical health of their populations and thereby boost the productivity of their workforces.⁶⁴ As well as strategies to tackle tuberculosis, alcoholism and syphilis, “mental hygiene” strategies were adopted to promote the early treatment of mental illness, to prevent the onset of mental illness through education of the public on life-style and mental health issues.⁶⁵ The principles of mental hygiene emphasised the psychological and social aspects of mental disorder, and served to add weight to arguments against a solely organicist interpretation.

3.1.8 Mental Hygiene

The International Mental Hygiene Movement, which spawned national organisations in France and England after World War I, originated in the USA in 1909 where it was associated with the growing interest in psychology.⁶⁶ The chief purposes of the Movement, as reported by the *Journal of Mental Science* in 1923, were to conserve mental health; promote the study of mental disorders and intellectual impairment; to obtain and disseminate information regarding mental health; help raise standards of care and treatment; and co-ordinate the activities of national organisations.⁶⁷ The Movement recognised that the conservation of mental health was a “matter of supreme economic importance to any nation”.⁶⁸ Although part of the International Mental Hygiene Movement, with its

⁶² Thomas, *Treating the Trauma of the Great War*, 153.

⁶³ Ibid., 69.

⁶⁴ See: Greta Jones, *Social Hygiene in Twentieth-Century Britain* (London: Croom Helm, 1986).

⁶⁵ Mathew Thomson, “Mental Hygiene in Britain During the First Half of the Twentieth Century: The Limits of International Influence,” in *International Relations in Psychiatry: Britain, Germany, and the United States to World War 2*, ed. Volker Roelcke, Paul J. Weindling, and Louise Westwood (Rochester, NY: University of Rochester Press, 2010), 137.

⁶⁶ Ibid., 134-5.

⁶⁷ AU, “The National Council for Mental Hygiene,” *Journal of Mental Science* July (1923): 404.

⁶⁸ Ibid.

established channels for the sharing of ideas and practices, the work of national mental hygiene organisations varied according to prevailing social and economic conditions, and each organisation had their own national characteristics.⁶⁹ This was in part driven by the character and priorities of the individuals steering the organisations.

In France, Édouard Toulouse, socialist, eugenicist and CMO at the Villejuif Asylum, founded the French League of Mental Hygiene with doctors Joseph Briand and Georges Génil-Perrin in 1920.⁷⁰ Toulouse, a forceful personality and a long-standing advocate of preventative psychiatry and public health reform, sought to re-organise the whole of society along scientific lines.⁷¹ The French League was driven by Toulouse's passion not only for asylum reform and a desire to establish an "open service",⁷² but by his commitment to tackling the root causes of mental illness, such as poverty, unhealthy life-styles, tuberculosis, syphilis and alcoholism.⁷³ Toulouse's passion for reform made him a divisive figure. He tended to alienate those who did not share his vision, a factor that perhaps shaped the reaction of his more conservative colleagues towards his approach to psychiatry and to the Mental Hygiene League that he founded. Toulouse has been described as an "*organiciste tempéré*".⁷⁴ At the beginning of his career, Toulouse was an organicist, but the more he focused on the preventative agenda of the Mental Hygiene Movement the more he became convinced of the role played by social factors in causing mental disorder. Biological factors were always going to be fundamental, and it was essential to conduct thorough investigations into physical factors, such as the metabolism of the brain, or anatomical changes within the nervous system, but at the same time, the life-style and character of an individual had to be considered. Toulouse maintained in 1926 that, "For historical reasons, [psychiatrists] have remained organicists for too long ... it must be remembered that mental illness is also affected by the social character of the individual".⁷⁵ He went on to say that the organicists

⁶⁹ Thomson, "Mental Hygiene in Britain," 135.

⁷⁰ Ohayon, *L'impossible Rencontre*, 32.

⁷¹ For an account of Toulouse's ambitions to establish society along such lines, see: Huteau, *Psychologie, Psychiatrie Et Société Sous La Troisième République*, 96.

⁷² The provision of psychiatric treatment for the poor without the need for internment according to the law of 1838; similar to the British concept of "voluntary" treatment.

⁷³ Thomas, *Treating the Trauma of the Great War*, 148.

⁷⁴ Huteau, *Psychologie, Psychiatrie Et Société Sous La Troisième République*, 10.

⁷⁵ *Ibid.*, 210.

did not pay sufficient attention to problems of “maladaptation” to a patient’s social situation; social factors could not be overlooked in the genesis of psychosis.⁷⁶

His views were very much in tune with those of the influential American psychiatrist Adolf Meyer (a key figure both in the establishment of the American Mental Hygiene Movement and in the development of occupational therapy). Both men took a holistic view of mental disorder. Meyer defined it as a form of “maladjustment” or a state in which individuals were no longer able to respond adequately to their environment.⁷⁷ Meyer used the term “psychobiology” to describe his approach, which enabled him to overcome the great divide between an organicist and a psychological approach to mental illness.⁷⁸ Toulouse developed a similar concept that he referred to as “*la biocratie*”.⁷⁹ This holistic approach was at odds with that of most of Toulouse’s colleagues, who continued to hold an organicist view of mental disorder.

The British National Council for Mental Hygiene (NCMH), founded in 1922, was not driven by one man’s vision in quite the same way. Many of the British NCMH’s founder council members were eminent psychiatrists, including Sir Frederick Mott, Hubert Bond, Hugh Crichton-Miller and Alfred Tredgold, psychologists Charles Myers and W.H.R. Rivers, and neurologist Henry Head, while the Council’s first president was philanthropist and businessman, Sir Courtauld Thomson.⁸⁰ The members’ varied interests ensured that the principles of mental hygiene were more likely to spread, but the movement lacked the drive and passion of its proponent in France. Mott and Tredgold were members of the Council of the Eugenics Education Society. Henry Head, like Toulouse, was concerned by industrial fatigue and worker efficiency, maintaining that “much industrial unrest was due to the worry and fatigue induced by unsatisfactory working conditions”.⁸¹ Psychologist C.S. Myers, after serving as consultant psychologist to the British Army in France during World War I,

⁷⁶ Ibid.

⁷⁷ Hans Pols, “‘Beyond the Clinical Frontiers’: The American Hygiene Movement 1910-1945,” in *International Relations in Psychiatry: Britain, Germany and the United States to World War 2*, ed. Volker Roelcke, Paul Weindling, and Louise Westwood (Rochester: University of Rochester Press, 2010), 113-4.

⁷⁸ Susan Lamb, “Social Skills: Adolf Meyer’s Revision of Clinical Skill for the New Psychiatry of the Twentieth Century,” *Medical History* 59, no. 3 (2015): 446.

⁷⁹ Huteau, *Psychologie, Psychiatrie Et Société Sous La Troisième République*, 9.

⁸⁰ AU, “National Council for Mental Hygiene,” *British Medical Journal* May 13 (1922):766.

⁸¹ Ibid., 767.

founded and became the director of the National Institute of Industrial Psychology in 1922.⁸² W.H.R. Rivers' speciality was applied psychology while Hubert Bond, a member of the Board of Control, was a strong advocate of voluntary treatment. The extent to which their views influenced patient work in mental hospitals, is difficult to pinpoint. There are three areas, however, where mental hygiene may have impacted on how patients were employed: industrial hygiene, occupational therapy and after-care. Another significant area of influence, although less directly related to patient work, was the mental hygienists' commitment to removing the legal formalities that acted to postpone the early, effective treatment of mental disorders.

The English mental hygienists' campaign for free "voluntary" care (that is, without certification) contributed to the eventual passing of the Mental Treatment Act in 1930.⁸³ This Act enabled poorer patients to be admitted to British mental hospitals on a voluntary or temporary basis. It was welcomed by the British NCMH which urged that full use be made of the opportunities it afforded.⁸⁴ The Board of Control regarded the Act as "the most important event ... in the year" and one that marked "an epoch in the treatment of mental disorders in this country".⁸⁵ As Mathew Thomson put it, the Act "promised to turn the asylum into a place of treatment and cure, rather than of long-term custody".⁸⁶ This change in focus from custody to treatment had implications for patient work, since an emphasis on treatment promoted the adoption of occupational therapy. The type of occupation that was suitable for acute, curable patients was different to that which was considered appropriate for chronic, incurable patients. The Act did not greatly affect treatment at Bethlem or the Maudsley, which already specialised in acute cases, but at the Littlemore growing numbers of acute patients increased requirements for intensive treatment and for occupations suitable for patients at the early stages of their disease.

⁸² F.C. Bartlett, "Obituary: Dr Charles S. Myers CBE, FRS," *Nature* 4019 (1946): 658.

⁸³ Prior to 1930, the only hospital in England offering free voluntary care was the Maudsley Hospital in London, which opened in 1923. The NCMH could not claim any credit for the opening of the Maudsley Hospital, however, as this had been in the pipeline since before World War I.

⁸⁴ AU, "National Council for Mental Hygiene," *British Medical Journal* Feb 21 (1931): 321.

⁸⁵ Seventeenth Report of the BoC, 1930, 1.

⁸⁶ Thomson, "Mental Hygiene in Britain," 143.

The first objective identified by the British National Council for Mental Hygiene (NCMH), to improve the mental health of the community, included a commitment to a “closer and more critical study of the social habits, industrial life and environments” of individuals, with a view to combatting those factors leading to mental ill-health and unhappiness.⁸⁷ This suggested that the NCMH was committed to addressing ways of improving working environments from a mental health perspective. In an article on the practical application of mental hygiene in industry, the potential for dissatisfied workers to develop mental disorders was highlighted. The author maintained that “a man should have pleasure in his work and a feeling that it is worthwhile”; many workers had neither of these and were mere “drudges”.⁸⁸ Employers needed to bring in psychiatrists to study the conditions affecting the mental health of workers and to assess their efficiency. Psychiatrists could assist in the “difficult task of fitting men to the jobs they can best do, and jobs to the men they need”.⁸⁹ This concept of “industrial hygiene” influenced how patient work was perceived in mental hospitals, leading to accusations that it was exploitative and constituted “mere drudgery”.⁹⁰

Another area where the mental hygienists were influential was in the area of supporting recently discharged patients. A sub-committee of the NCMH was tasked with “facilitating the organisation of After-care”.⁹¹ Supporting patients after discharge, and helping them find employment, helped prevent a relapse of symptoms. The mental hygienists were instrumental in augmenting after-care provision and in promoting the use of psychiatric social workers who liaised between the hospital and the local community.⁹² J.R. Lord, superintendent of London’s Horton Hospital and member of the British NCMH, sought to introduce convalescent homes for recently discharged patients. He maintained that the “rehabilitation and industrial training, the teaching of new occupations, the remoulding of character and the consolidation of the shattered personality” begun in the mental hospital, would be brought to a more successful conclusion if patients could continue with such

⁸⁷ AU, “International Mental Hygiene Movement,” 405.

⁸⁸ W.J.A. Erskine, “Epitome of Current Literature: Mental Hygiene,” *Journal of Mental Science* Apr (1923): 241-2.

⁸⁹ *Ibid.*, 243.

⁹⁰ This was the tone of press coverage following the accusations made by Dr Montagu Lomax, discussed in the following chapter. Patient work was also described by Dr D.K. Henderson as “mere drudgery” in his psychiatric textbook first published in 1927.

⁹¹ AU “The National Council for Mental Hygiene”, *Journal of Mental Science* Oct (1924): 711.

⁹² Thomson, “Mental Hygiene in Britain,” 142.

treatment in specially equipped facilities before having to live independently.⁹³ This would also have the advantage of freeing up beds in mental hospitals for more acute cases. Working with patients and local employers to identify suitable employment opportunities was a process that began prior to discharge, either from hospital or from a convalescent home. These were all measures that indicated an increasing level of sophistication with regard to the after-care and future employment prospects of patients.

In France, Toulouse used the French League of Mental Hygiene as a platform for launching his campaign to establish an “open” psychiatric service⁹⁴ in Paris for the treatment of patients whose condition was sufficiently mild to avoid internment according to the law of 1838. He obtained the support of several politicians, notably Councillor Henri Rousselle and Health Minister Justin Godard, but many psychiatrists remained opposed to the project.⁹⁵ Despite opposition from colleagues, the *Service Libre de Prophylaxie Mentale* (SLPM) opened in 1922 in the grounds of Ste Anne’s.⁹⁶ The service comprised a dispensary, a hospital, various laboratories and a social services department. For the first time, poor patients could access free psychiatric treatment, as “in-patients” or “out-patients”, without having to be certified.⁹⁷ Toulouse recognised the benefits of psychiatric social work and its role in helping patients to secure employment after leaving hospital; this comprised an essential aspect of the SLPM.⁹⁸ The system designed by Toulouse was far more comprehensive in its support for patients both inside and outside hospital than that which was provided by most French asylums.

Toulouse wanted the opportunity to treat individuals with acute symptoms or those at the early, mild stage of mental illness, before their conditions deteriorated and warranted internment.⁹⁹ He had been campaigning for a more flexible system of treatment since

⁹³ J.R. Lord, “‘After-care’ and Other Aspects of Social Service as an Adjunct to Mental Treatment,” *Journal of Mental Science* Oct (1930): 623.

⁹⁴ The phrase “open services” were used to describe mental hospitals for which patients did not have to be certified; admission was voluntary.

⁹⁵ Ohayon, *L'impossible Rencontre: Psychologie Et Psychanalyse En France 1919-1969*, 32.

⁹⁶ The SLPM became known as the Henri Rousselle Hospital in 1926, named after its most ardent supporter on the General Council who died that year.

⁹⁷ Henri Rousselle, “Rapport au nom de la 3e Commission sur le Service departmental de prophylaxie mentale et les service annexes,” *Conseil Général de la Seine*, 1923, 3-4. Archives de Paris, Series D.10K3, Article 34, Report No.87.

⁹⁸ Ibid.

⁹⁹ Ibid., 6.

visiting Scotland in 1897 where he witnessed the Scottish “open door” system.¹⁰⁰ He believed that a similar system could help to relieve overcrowding in French asylums and improve outcomes for acute patients. His arguments for reform were bolstered after World War I by the need to strengthen the physical and mental health of war survivors, many of whom (both military and civilian) were traumatised by the experience of war and by the economic instability of the post-war period.¹⁰¹ Toulouse was acutely aware of the need to rebuild the nation’s workforce after the war, claiming in 1920 that “the nation’s biggest problem was the re-establishment of its human capital”.¹⁰² His priority was keeping people out of the asylums, of which he was extremely critical. Either he wanted patients to remain in their homes and regular professions while receiving treatment in outpatient facilities, or for their stay in hospital to be brief, but effective, allowing them to return home and to the workforce as quickly as possible.

3.1.9 Alienism or Psychiatry during the Interwar Period

The new approach to psychiatric care taken by Toulouse and his colleagues at the Henri Rousselle Hospital was not welcomed by the alienists working in asylums, for whom it represented a threat. Alienists, who held an organicist interpretation of mental disorder, were invested in the custodial model of psychiatric care. The ongoing cleavage between alienism and psychiatry, which remained marked outside the capital, attracted the attention of Aubrey Lewis (who joined the Maudsley Hospital staff in 1929 and was appointed Clinical Director in 1936) during his tour of European psychiatric institutions in 1937. His subsequent report offers a useful insight into the approach of French interwar institutions. While he was in Paris, Lewis observed that “the gulf between the ‘*médecins des hôpitaux*’ and the ‘*médecins des asiles*’ [was] wide”.¹⁰³ By this he meant that hospital doctors, such as those practising at the Henri Rousselle Hospital and Henri Claude’s Faculty Clinic, took a more holistic view of mental illness and were engaged in active treatment, including

¹⁰⁰ Edouard Toulouse, “Rapport au Conseil Général de la Seine au nom de la commission chargée d’étudier l’assistance des aliénés en Angleterre et en Ecosse,” *Conseil Général de la Seine*, 1898. ADP/D.10K3/12.

¹⁰¹ Gregory M. Thomas, “Open Psychiatric Services in Interwar France,” *History of Psychiatry* 15, no. 2 (2004).

¹⁰² Jean-Bernard Wojciechowski, *Hygiène Mentale Et Hygiène Sociale: Contribution À L’histoire De L’hygiénisme*, vol. 2 (Paris: L’Harmattan, 1997), 41.

¹⁰³ Aubrey Lewis, “Report on Visits to Psychiatric Centres in Europe 1937,” in *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital and the Rockefeller Foundation in the 1930s*, ed. Katherine Angel, Edgar Jones, and Michael Neve (London: Wellcome Trust Centre, 2003), 81.

psychotherapy, while asylum doctors were more likely to hold a traditional organicist stance and to offer only custodial care. Lewis maintained that French asylum medicine drew on its heritage of neurology, hysteria and neurosis, and was intent on identifying physical causes of mental illness.¹⁰⁴ Furthermore, Lewis observed that there did not appear to be much communication between the various sectors of French psychiatry.

Although psychotherapy and psychoanalysis had begun to make in-roads into French psychiatry in the 1920s, it was very much “on tiptoe”.¹⁰⁵ Organisations such as the *Société de l'Évolution Psychiatrique*, the *Mouvement Psychanalytique Français* had emerged and the *Revue Française de Psychanalyse* appeared 1926, but the numbers involved were small and all were based in Paris.¹⁰⁶ Lewis noted that the “more progressive people” were associated with Eugène Minkowski’s *Évolution Psychiatrique* group (also Parisian), whose main interest was psychopathology.¹⁰⁷ Rather than trying to explain mental disorder in terms of brain lesions, psychopathologists concentrated on the clinical observation of symptoms, putting them at odds with the neurologists, who regarded the *Évolution Psychiatrique* group somewhat contemptuously.¹⁰⁸ The group mainly comprised hospital doctors (many were attached to the SLPM, including Georges Heuyer, or to Professor Claude’s Faculty Clinic at Ste Anne’s, such as Jacques Lacan and Henri Ey) and psychiatrists working outside the asylum system. Most asylum doctors, concluded Lewis, had “very little opportunity” to experience “the more psychological side of therapy”.¹⁰⁹ As French historian of psychiatry Jacques Guyotat observes, psychoanalysis did not impinge on neuro-psychiatry, but it had considerably more influence at the psychiatric hospital level, thereby reinforcing the division between the “resolutely” organicist stance of the asylums and the social psychiatry (that is, an approach focused on the relationship between mental health and an individual’s social environment) associated with psychoanalysis, of psychiatrists working in private practice and at the Parisian mental hospitals.¹¹⁰ The organicism of French asylum medicine was at

¹⁰⁴ Ibid., 79.

¹⁰⁵ Ibid.; Postel and Quétel, *Nouvelle Histoire De La Psychiatrie*, 350.

¹⁰⁶ Ibid.

¹⁰⁷ Psychopathology was defined by Bernard Hart (1879-1966) in 1912 as “the science which attempts to explain the problems of mental disorder by psychological principles” (Bernard Hart, *The Psychology of Insanity*, 4th Edition, Cambridge University Press: 1930, xv).

¹⁰⁸ Lewis, “Report on Visits to Psychiatric Centres in Europe 1937,” 80.

¹⁰⁹ Ibid., 81.

¹¹⁰ Guyotat, “La Formation Des Psychiatres En France,” 70.

odds with Lewis' own views; he maintained the psychobiological perspective of most of the Maudsley psychiatrists, who were heavily influenced by Adolf Meyer.

3.1.10 Towards Psychiatry in England

In England, ideological changes within psychiatry, which began before World War I and developed during the war and as a result of the Mental Hygiene Movement, were further stimulated during the interwar period by the Macmillan Report of 1926. This radical report was produced following a Royal Commission on Lunacy and Mental Disorder, established by the Ministry of Health in 1924. The Commission was formed in response to criticisms of the asylum system published in a widely read critical account of asylum management by Dr Montagu Lomax;¹¹¹ to the deficiencies of the Board of Control;¹¹² and to the changing attitudes towards mental disorder brought about by World War I and earlier developments in psychology.¹¹³ The Commission declared that they could not identify any satisfactory distinction between physical and mental illnesses, and concluded that all illnesses should be managed similarly. In this, they were advocating an approach based on the continuity of mental disorder. They maintained that the aim of psychiatry should no longer be the containment and isolation of individuals with the most severe conditions. Anyone suffering from a mental illness, whether severe or mild, should have access to treatment, either at home, at an outpatients' clinic, in a general hospital or in a mental hospital, depending on the patient's needs and the availability of facilities. Certification or compulsory admission should be a very rare occurrence.¹¹⁴ Psychiatrists should have specialist training and should not be overloaded with cases, nor expected to spend too much time on administration. Mental nurses should also be properly trained and carefully recruited. Mental hospitals should be small, comfortably furnished and well-equipped.¹¹⁵

¹¹¹ Lomax's book, *The Experiences of an Asylum Doctor* [1921], was based on his experience of working at the Prestwich Asylum near Manchester from 1917 to 1919.

¹¹² Indicated by a recent court case involving Dr Hubert Bond, a commissioner of the Board, in which a patient alleged eight years' wrongful detention.

¹¹³ Crammer, "Training and Education in British Psychiatry," 228.

¹¹⁴ Ibid.

¹¹⁵ Ibid.

The Macmillan Report signalled a change in attitude, with an emphasis on treatment rather than custodial care, that was promoted by the Board of Control (BoC). This impacted upon attitudes towards patient work, which was to be re-orientated towards therapeutic goals, rather than economic ones. Occupational therapy (OT), which had emerged in the USA and Germany just before World War I, afforded a new means of treating patients at a time when few effective treatments existed (malaria therapy, discovered in 1917, was only effective at treating patients suffering from GPI). The Report also led to the passing of the Mental Treatment Act in 1930, which provided for the voluntary admission to all public mental hospitals (only possible at the Maudsley until 1930) of patients who could discharge themselves on giving 72-hours' notice.¹¹⁶ By 1938, nearly 38% of all admissions to English public mental hospitals were voluntary.¹¹⁷ This meant that a greater proportion of patients were admitted at the early, curable stage of their illness, thereby increasing the need for effective treatment. In the case of occupation, this called for OT rather than unstructured and relatively unsupervised work. This in turn, required well-trained, specialist staff capable of supervising and delivering OT.

Part II: Professionalisation within Psychiatry, Mental Nursing and Occupational Therapy

3.2.1 Training for French Asylum Doctors

In France, according to the law of 30 June 1838, asylums were staffed by full-time physicians who were appointed by the Minister of the Interior. The law also made provision for students to be attached to the asylums to ensure the transmission of psychiatric knowledge.¹¹⁸ This system of training lasted until 1949; there were no specialist academic courses of instruction, nor any qualifications in psychiatry until then. Medical students entered the asylum as an "*interne*" in their final year of study. In the larger cities, notably in Paris, internship was competitive, by "*concours*", while in the provinces, entry was by

¹¹⁶ Gittins, *Madness in Its Place*, 40.

¹¹⁷ Ibid.

¹¹⁸ Jan Goldstein, "Psychiatry," in *Companion Encyclopedia of the History of Medicine*, ed. W. F. Bynum and Roy Porter (London and New York: Routledge, 1994), 1360.

“cooptation”, or recommendation.¹¹⁹ This perpetuated the neuro-psychiatric orientation of asylum medicine.

The post of Chair of Mental Disorder, based at the Faculty Clinic at Ste Anne’s, was given to individuals with a predominantly neurological background, including Benjamin Ball (1833-93), Alexis Joffroy (1844-1908), Gilbert Ballet, Ernest Dupré (1862-1921) and Henri Claude (1869-1945).¹²⁰ There was no specific training in psychiatry at university level. A Certificate in Neuro-psychiatry was created in 1949 by university Chairs of Neurology, but the syllabus for this was usually taught by neurologists, for whom psychiatry was considered the “poor relation”.¹²¹ Psychiatry did not become an autonomous discipline in France until 1968.¹²² This perpetuation of an organicist approach to mental disorder was facilitated by the delay in establishing psychiatry as an autonomous discipline and, in turn, discouraged the adoption of new approaches to patient occupation.

3.2.2 Training for English Asylum Doctors

Specialist training, which the Macmillan Report had advocated, was not required for medical officers working in mental hospitals. Medical officers had to be qualified doctors (this had been made law in 1828), but most physicians learned about the specifics of care for the mentally disordered through practical experience gained in their asylum, and from books and journals.¹²³ The Medico-Psychological Association (MPA) instituted a Certificate in Psychological Medicine in 1885. It was never very popular, and was based on vocational rather than academic knowledge, but by 1896 some 240 people held the certificate.¹²⁴ In 1892, the MPA, aware of the shortcomings of the Certificate, established an Educational Committee to explore options for expanding and improving training and qualification. The Diploma in Psychological Medicine (DPM) was created in 1908-10, and universities were invited to participate. The DPM involved written and practical tests in psychology, anatomy and physiology, together with questions on asylum administration and legislation.¹²⁵ The

¹¹⁹ Guyotat, "La Formation Des Psychiatres En France," 70.

¹²⁰ F. Clarac and F. Boller, "History of Neurology in France," in *Handbook of Clinical Neurology*, ed. S. Finger, F. Boller, and K.L. Tyler (Amsterdam: Elsevier B.V, 2010), 645.

¹²¹ Guyotat, "La Formation Des Psychiatres En France," 70.

¹²² Ibid., 72.

¹²³ Crammer, "Training and Education in British Psychiatry," 211.

¹²⁴ Bewley, *Madness to Mental Illness*, 126.

¹²⁵ Crammer, "Training and Education in British Psychiatry," 221.

examination could only be taken two years after medical qualification and following at least three months' clinical experience in a mental hospital. The first DPM examinations were first taken at Leeds University in 1911 and at Cambridge and Edinburgh Universities in 1912, following courses of instruction at those institutions.¹²⁶ Candidate numbers remained small before the outbreak of World War I, and it was not until the opening in 1923 of the Maudsley Hospital, which offered a six-month course of intensive lectures and demonstrations delivered by high-profile teachers, that the DPM began to attract candidates in double figures.¹²⁷ The syllabus was extended in 1928 and 1933. The DPM, while it did not become a pre-requisite for a post in a mental hospital during the 1920s and 1930s, marked a significant step in the professionalisation of psychiatry in Britain and its establishment as an independent, academic discipline. Improving standards of psychiatric care depended not only on the training and qualification of doctors, but also on that of the mental nurses who worked alongside them.

3.2.3 Mental Nurse Training in England

Although mental nursing attracted criticism in interwar England (as well as in France), the professionalisation of mental nursing was further ahead than in France in terms of the availability of training and a standardised manual, and the establishment of nationally recognised qualifications. Furthermore, there appeared to be a considerable difference between the quality of nurses working at the Maudsley, Bethlem and Littlemore hospitals and the other public mental hospitals at which the criticisms were directed. A handbook for nurses and attendants, produced by the MPA, had been available since 1885;¹²⁸ this ran to numerous editions (the seventh appearing in 1923) until 1978. The first national training course and examination, resulting in a Certificate of Proficiency in Nursing the Insane, was established by the MPA in 1891. By 1899, 100 asylums were participating in the training scheme, the duration of which was extended to three years in 1908.¹²⁹ Uptake of the national training scheme and use of the Handbook brought greater unity amongst asylum nurses, leading to the founding of the National Asylum Workers' Union in 1910, a union run

¹²⁶ Ibid.

¹²⁷ Ibid., 222.

¹²⁸ Medico-Psychological Association, *Handbook for the Instruction of Attendants on the Insane* (London: Ballière, Tindall and Cox, 1885).

¹²⁹ Peter Nolan, "Mental Health Nursing in Great Britain," in *150 Years of British Psychiatry*, ed. H.L. Freeman and G.E. Berrios (London: Athlone Press, 1996), 178.

by nurses for the advancement of nursing.¹³⁰ The latter enabled nurses to lobby for better pay and conditions; a series of strikes organised by the Union in 1918 resulted in an increase in pay.¹³¹ The establishment by the General Nursing Council of its own training programme for mental nurses in 1919, leading to the qualification of Registered Mental Nurse, created a certain rivalry between the GNC and MPA. From 1922, when the examinations were first taken, until 1951, the MPA and the GNC ran parallel training schemes.¹³² This dual system, involving two sets of examinations based on a “practically identical curriculum”, was described by the BoC as “unsatisfactory”, although competition between the two providers may have helped to raise standards and offered nurses a choice.¹³³

The adverse comments made about mental nursing made by Lomax in 1921 led to an enquiry by the Board of Control’s Committee on Nursing in County and Borough Mental Hospitals. Published in the *Journal of Mental Science* in 1925, the report recommended a “national nursing service ... a service in which the same qualifications are recognised and required at all institutions for the same positions”.¹³⁴ The MPA was striving to achieve this, but the GNC’s intervention had made the situation more complex. The Committee emphasised that quality nursing depended upon “adequate training” based on theoretical and practical instruction by qualified teachers.¹³⁵ Mental hospitals were urged to encourage more nurses to undergo training, since only half of mental hospital nurses were trained or undergoing training. Although the BoC observed a reluctance amongst female nurses to become qualified, some hospitals insisted on it, including the Maudsley.¹³⁶ Training was incentivised at Bethlem by the offer of an additional two shillings per week for those obtaining the MPA Nursing Certificate.¹³⁷ These measures indicate that the process of professionalisation within mental nursing in England, while far from complete, was further advanced than in France.

¹³⁰ Ibid., 179.

¹³¹ Ibid.

¹³² Ibid., 180.

¹³³ Fifteenth Annual Report of the BoC, 1928, 4.

¹³⁴ AU, “Board of Control Report from Committee on Nursing in County and Borough Mental Hospitals,” *Journal of Mental Science* April (1925): 289-90.

¹³⁵ Ibid.

¹³⁶ Ibid.

¹³⁷ AU, “Nursing in the Bethlem Royal Hospital,” *The Hospital* 8 Jan (1921): 346.

An improvement in nurses' pay and conditions was seen as key to further raising standards.¹³⁸ Conditions were considerably more favourable in city institutions, such as the Maudsley and Bethlem Hospitals, which were therefore able to attract a higher calibre of nurse. At the Maudsley, nurses' accommodation was described as "excellent" in 1923, while at Bethlem, the pay for probationer nurses was described in an article in *The Hospital* in 1921 as "far in excess of that usually accorded to learners".¹³⁹ Nursing standards at the Maudsley Hospital were praised in the Board's annual inspection reports. In 1926, the Board remarked that "everything is being done not only for the restoration to health but for the comfort of the patients".¹⁴⁰ While the same cannot be said for all English provincial mental hospitals, nursing standards at Oxford's Littlemore Hospital, where training was encouraged, were also high. Nurses were entrusted with aiding the doctors in their provision of psychotherapy and were responsible for delivering OT to patients.¹⁴¹ Nurses were also given the opportunity to gain general nursing experience by the instigation of a nurse exchange scheme organised with the Radcliffe Infirmary by the Littlemore MS, Dr Saxty Good.¹⁴²

3.2.4 Mental Nurse Training in France

The adoption of OT in French institutions was hindered by poor nursing standards. Efforts were made to professionalise mental nursing by Seine psychiatrists, Théodore Simon and Georges Daumézon, but progress was slow and the standard of mental nursing care in French asylums attracted widespread criticism.¹⁴³ This was in part a matter of training. Formal training in mental nursing was rare in France in the immediate aftermath of World War I. It was provided in some departments, including the Seine, where a mental nursing school was established at Ste Anne's in 1882 and at other Seine asylums in 1907, but provision outside the capital was patchy.¹⁴⁴ A State Diploma, requiring a year's training (increased to two years in 1924), was introduced in 1922, but it was not compulsory. The

¹³⁸ AU, "Board of Control Report from Committee on Nursing in County and Borough Mental Hospitals," 301.

¹³⁹ AU, "Nursing in the Bethlem Royal Hospital," 346.

¹⁴⁰ Thirteenth Annual Report of BoC 1926, 145-6.

¹⁴¹ Thomas Saxty Good, "The History and Progress of the Littlemore Hospital," *Journal of Mental Science* Oct (1930): 614.

¹⁴² *Ibid.*, 615.

¹⁴³ Alexander Klein, "Théodore Simon (1873-1961): Itinéraire D'un Psychiatre Engagé Pour La Professionnalisation Des Infirmiers Et Infirmières D'asile," *Recherche en soins infirmiers* no. 135 (2018): 91-106.

¹⁴⁴ Elisabeth Jean-Louis and Aline Valentin, "Un Institut Au Coeur de L'Histoire de La Profession Infirmière," in *L'Hôpital Sainte-Anne: Pionnier De La Psychiatrie Et Des Neurosciences Au Coeur De Paris*, ed. Stéphane Henry, Catherine Lavielle, and Florence Patenotte (Paris: Somogy Éditions d'Art, 2016), 170.

educational standards of those nurses who took the examination compromised their chances of success. In the Seine, 28 out of 40 student nurses failed the diploma in 1922, as a result of poor communication skills.¹⁴⁵ Thirteen years later, Daumézon again criticised the level of education achieved by mental nurses, only 5% of whom held a certificate of primary education in 1935, and some of whom were illiterate.¹⁴⁶ Manuals were available, including Roger Mignot and Ludovic Marchand's *Manuel technique de l'infirmier des établissements psychiatriques* (first published in 1912, with a second expanded edition appearing in 1930), and Antony Rodiet's *Manuel des infirmiers et infirmières des hôpitaux et des asiles* (1928) which were based on "modern republican medicine".¹⁴⁷ But their usefulness depended on the nurses' ability and inclination to study them.

In 1925, General Councillor Chausse referred to the need to eliminate "useless" staff from Seine asylums.¹⁴⁸ French nurses were compared unfavourably with their Dutch counterparts by Seine psychiatrist, Paul Courbon. After visiting the Dutch asylum at Santpoort in 1929, Courbon observed that Dutch nurses regarded the profession as a vocation, rather than just a job, and they were recruited from a more highly educated and cultivated class than in France.¹⁴⁹ Similar observations were made by Daumézon in 1935. He noted that nurses tended to be recruited from peasant or labouring stock and lacked a vocational calling to their profession.¹⁵⁰ From 1930, a new five-year training scheme was offered to nurses, but this was optional and did little to improve overall standards.¹⁵¹ Poorly trained nurses were unlikely to cope with new methods of OT that demanded careful patient supervision.

One factor complicating standards within French female mental nursing was the fact that some asylums employed nurses from religious orders and in others, nursing was secular. In Paris and other large cities, where republican values predominated, the secularisation of

¹⁴⁵ Henri Rousselle, "Rapport au nom de la 3e Commission sur l'Asile Clinique et sur le Service libre de prophylaxie mentale," CGS, 1922, 3. ADP/D.10K3/32/77.

¹⁴⁶ Patrice Krzyzaniak, "Georges Daumézon (1912-1979): Un Camisard Psychiatre Et Pédagogue: Une Contribution Singulière Aux Sciences De L'éducation" (Université Charles de Gaulles, 2018), 89.

¹⁴⁷ Hervé Guillemain, "Le Soins En Psychiatrie Dans La France Des Années 1930," *Histoire, Médecine et Santé* Spring, no. 7 (2015): 81-2.

¹⁴⁸ M.E. Chausse, "Rapport Général au nom de la 3e Commission sur le compte du Service des aliénés pour 1924, le budget rectificatif de 1925 et le projet de budget pour 1926," CGS, 1925. ADP/D.10K3/38/83.

¹⁴⁹ Paul Courbon, "Voyage d'études dans les asiles de Hollande," *Annales Médico-Psychologiques* no. 2 (1928): 399.

¹⁵⁰ Ibid.

¹⁵¹ Krzyzaniak, "Georges Daumézon," 91.

asylum personnel took place in or before 1905,¹⁵² when all state institutions officially became secular.¹⁵³ In the provinces, particularly in areas where support for the Church remained strong, secularisation was piecemeal and occurred much later.¹⁵⁴ At the Asile de la Sarthe, for example, where nursing on the women's side of the asylum had been provided by the religious order of the *Charité d'Evron* since 1870, secularisation did not occur until the 1960s.¹⁵⁵ Fears were expressed by the secular psychiatrists of the Seine that employing nuns as nurses created a "state within a state" that impeded the introduction of modern methods.¹⁵⁶ Whether these fears were justified is hard to ascertain, but at the ADLS, nursing "sisters" were regularly praised by the CMO, Dr Christy, for their diligence and devotion to duty, while their (secular) male colleagues attracted harsh criticism.¹⁵⁷ Christy, who came to Le Mans from the republican city of Lyon, did not appear to regard his religious nursing staff as an impediment to his pursuit of modern treatment methods. That said, the nursing manual prepared specifically for religious nurses by the staunch Catholic CMO of the Rouffach Asylum, Franz Adam, was quite different in tone to the manuals used by the secular nurses in the Seine asylums. Adam encouraged nurses to treat patients as they would their father, brother or child.¹⁵⁸ The role of the nurse, in Adam's view, was to provide spiritual and moral guidance to patients as well as care.¹⁵⁹ Adam was greatly impressed by Hermann Simon's method of MAT, outlined in the journal *L'Hygiène Mentale* in 1933, which inspired his views on the duties of nurses.¹⁶⁰ Adam saw patient work as a means of "moral" treatment, instilling a sense of duty, discipline and of serving the asylum community.

¹⁵² The Bill of Separation passed in 1905 ended the Napoleonic Concordat that had protected the relationship between the Catholic Church and the French state; henceforth all state institutions, including schools and hospitals, were to be run on a secular basis. See: Price, *A Concise History of France*, 234-5.

¹⁵³ Évelyne Salem and Stéphane Henry, "Laïcisation Et Formation Du Corps Soignant a L'asile Sainte-Anne," in *L'hôpital Sainte-Anne: Pionnier De La Psychiatrie Et Des Neurosciences Au Cœur De Paris*, ed. Stéphane Henry, Catherine Lavielle, and Florence Patenotte (Paris: Somogy éditions d'art, 2016), 167.

¹⁵⁴ Guillemain, *Chronique De La Psychiatrie Ordinaire: Patients, Soignants Et Institutions En Sarthe Du 19e Au 21e Siècle*, 41.

¹⁵⁵ Ibid., 42.

¹⁵⁶ Porot, "L'assistance par le travail," 51.

¹⁵⁷ Several of the ADLS Medical Reports ended with a reference to the invaluable services of the nursing "sisters", such as that of Dr Christy in 1935 (see above).

¹⁵⁸ Frantz Adam, *Devoirs de l'Infirmier des hôpitaux psychiatriques* (Colmar: Huffel, 1937).

¹⁵⁹ Guillemain, "Le Soins En Psychiatrie Dans La France Des Années 1930," 83.

¹⁶⁰ Ibid., 84.

Whether or not a hospital employed an occupational therapist (a profession that did not exist in France until the 1950s), nurses provided the framework within which OT or patient work took place. They were the individuals who spent most time with patients and were responsible for supporting or supervising occupation outside the OT treatment rooms or workshops. For this to be successful, nurses needed to be trained. The training course and examination required the student to have at least a basic level of school education. Nurses also needed to be empathetic and to have a degree of interest in and commitment to their profession in order to engage with patients and encourage their participation in work or OT. There also needed to be sufficient numbers of nurses on the wards to ensure that they had time to spend with patients; this was a matter of resources, which, as indicated above, were even more scarce in France than they were in England.

3.2.5 Occupational Therapy

The professionalisation of occupational therapy took place in England during the interwar period, but in France, where an organicist interpretation of mental disorder persisted until after World War II, the profession did not exist until the 1950s. As Larkin has suggested, developments within the medical professions were often responsible for the evolution of new paramedical professions;¹⁶¹ such developments occurred within psychiatry in England but not in France. The need for a profession of occupational therapy had not been created in France in the sense that psychiatrists, who regarded mental disorder from an organicist perspective, did not consider psychological treatments appropriate for physiological conditions. There was therefore little requirement for OT. In England, interwar psychiatrists embraced the “psychobiological” approach advocated by the American psychiatrist, Adolf Meyer, for which occupational therapy was an important aspect of treatment.

In England, the BoC first recommended that the larger mental hospitals appoint an “occupation officer” in 1924. This advice was expressed more strongly in 1928, with the warning that it was “never economical to understaff a hospital”.¹⁶² The Board emphasised that “carefully organised occupation [had] a definite therapeutic value” but that its teaching to patients required “specialist skill and experience”.¹⁶³ In 1931, the Board emphasised how

¹⁶¹ Larkin, “The Emergence of Para-Medical Professions,” 1333.

¹⁶² Fifteenth Annual Report of the BoC, 1928, 5.

¹⁶³ Ibid.

the appointment of a “skilled occupation officer” at one hospital had resulted in the provision of occupation for patients who would not hitherto have been considered employable in any capacity.¹⁶⁴ The BoC’s *Memorandum on Occupational Therapy* (1933) set out more comprehensively its vision for OT in England and again stressed the value of employing an occupational therapist to oversee the provision of occupation that was therapeutic rather than merely a distraction. That said, the Board noted in its *Memorandum* that trained occupational therapists were not considered essential for the delivery of MAT, the variant of OT practised at the asylums at Santpoort and Gutersloh.¹⁶⁵ At these institutions, occupation (which was based on the work required to run the institution) was supervised by the nurses, with a high level of involvement from the medical personnel. This model, however, presupposed that nurses possessed the requisite level of education, skill and commitment, qualities which French mental nurses lacked according to Seine psychiatrist, Paul Courbon. MAT also required high nurse to patient ratios, which French asylums also lacked.

Training to become an occupational therapist first became available in England at the Dorset House School of Occupational Therapy, which opened in Bristol in 1930. It was founded by Dr Elizabeth Casson who had been inspired by reports of Dr David Henderson’s 1924 conference on OT. Casson, after visiting hospitals in the USA to discover more about OT, introduced the practice at her private clinic for women, Dorset House, in Bristol. The Dorset House School of Occupational Therapy was attached to the clinic, with an American-trained occupational therapist, Constance Tebbit, as its principal.¹⁶⁶ The establishment of the school marked the start of the professionalisation of patient work and occupation in England and the emergence of a new specialty affiliated to medicine. This was in contrast to the pre-World War I period during which patient work was overseen by nurses and attendants who were not trained in the therapeutic application of occupation. This process of professionalisation followed that of OT in the USA, which began some 15 earlier.¹⁶⁷ Another

¹⁶⁴ Eighteenth Annual Report of the BoC, 1931, 9-10.

¹⁶⁵ Board of Control, *Memorandum on Occupational Therapy for Mental Patients* (London: HMSO, 1933), 9. <http://wellcomelibrary.org/item/b24957070>.

¹⁶⁶ Betty Collins, *The Story of Dorset House School of Occupational Therapy 1930-1949* (Bristol: Private Publication, 1951), 9.

¹⁶⁷ The first school of OT was founded in Chicago in 1915 and NSPOT was established in 1917. Professionalisation of OT did not happen in Germany or Holland until the 1950s. The most likely explanation

English school opened at the Maudsley Hospital in 1932. The course at the Maudsley was overseen by Dr Thomas Tennent, who had also worked with Adolf Meyer in the USA, thus re-affirming the methods of AOT.¹⁶⁸

The type of OT taught at both schools was the American style of OT that involved the teaching of arts and crafts to patients. A professional body, the Association of Occupational Therapists, was established in 1936 with former Dorset House student and future principal, Mary Macdonald, at its helm. The Association began publishing the quarterly *Journal of Occupation Therapy* and prepared an examination syllabus in 1938; the first cohort of students sat their examinations that year.¹⁶⁹ By 1939 there were an estimated 64 occupational therapists working in English mental hospitals, indicating that roughly half of all English mental hospitals had opted to employ an occupational therapist.¹⁷⁰ Other hospitals, like the Littlemore, chose to devolve responsibility for delivering OT to nurses.

In France, during the interwar period, nurses lacked the training to provide OT for patients and there were no occupational therapists. Attitudes towards the value of OT began to change after World War II. During the 1939-45 war, 45,000 mentally ill asylum patients died as a result of cold and hunger, prompting a radical reassessment of training in psychiatry and mental nursing.¹⁷¹ The French looked to England and Switzerland for models of mental nurse training. A new school of “psychiatric nursing” was established at the Maison-Blanche Asylum, Paris, in 1948.¹⁷² The syllabus included the social rehabilitation of the patient through occupational therapy (*l’ergothérapie*), with which the nurses were to be actively involved. OT comprised a range of activities, including work therapy, arts and crafts, exercise, games, drama, walks and social occasions.¹⁷³ OT began to develop as an

lies in the fact that MAT was conducted by the nursing staff, trained *in situ*, rather than by specially trained occupational therapists, as was the case with AOT.

¹⁶⁸ Hall, "From Work and Occupation to Occupational Therapy," 324.

¹⁶⁹ Ibid.

¹⁷⁰ Ibid., 326.

¹⁷¹ Goubert and Remondière, "Les Origines Historiques De L'ergothérapie En France," 262.

See also: Isabelle Von Bueltzingsloewen, *L'hécatombe Des Fous: La Famine Dans Les Hôpitaux Psychiatriques Français Sous L'occupation* (Paris: Éditions Flammarion, 2007).

¹⁷² Goubert and Remondière, "Les Origines Historiques De L'ergothérapie En France," 262.

¹⁷³ Ibid., 265.

independent profession in the 1950s; OT training schools opened in Paris and Nancy in 1954.¹⁷⁴

3.2.6 Conclusion

The fact that French psychiatry was slow to develop as a separate discipline, independent of neurology, impeded the development of a holistic interpretation of mental disorder that was receptive to the take-up of OT.¹⁷⁵ It was only in Paris, and more specifically, at the SLPM and the Faculty Clinic, that more psychological or psychobiological interpretations developed. When mental disorder was interpreted in this way, psychotherapy and re-educative methods, including OT, were considered beneficial. This interpretation was limited to Paris until after World War II because of the organicist stance of most psychiatrists outside the capital, who perceived mental disorder in purely neurological terms or in terms of hereditary degeneration. These psychiatrists preferred biological methods of treatment for curable conditions, whilst work remained a useful distraction for the chronically ill. Even if psychiatrists had been well disposed towards the introduction of OT, French nursing standards would have made this very difficult. In England, where psychiatry was more firmly established as an independent discipline, psychological interpretations of mental disorder were more widespread. This, together with a greater focus on treatment in mental hospitals following the Macmillan Report (1926) and higher standards of nursing care, which was more professional and less bound to religious orders and traditions, facilitated the adoption of OT. The latter, however, also depended on hospital infrastructure, admissions policies and finance. These are addressed in the following chapter.

¹⁷⁴ AU, "Historique des Instituts de Formation en Ergothérapie," Institut de Formation en Ergothérapie, <http://ergo-nancy.com/historique-metier.php> (accessed 03/03/2019).

¹⁷⁵ This approach, based on the American model, would develop after World War II.

Chapter 4:

From Patient Work to Occupational Therapy in French and English Institutions

4.0 Introduction

The successful incorporation of OT into mental hospital treatment regimes depended on high standards of nursing and the establishment of psychiatry as an independent discipline. In addition, certain conditions had to be met in terms of asylum management structures, admissions policies, legislation, and resources. The extent to which these conditions were met in French and English mental hospitals differed. In English mental hospitals, new approaches to OT were more readily accommodated because overall responsibility for the hospital lay with one doctor who could exercise his authority with regard to patient work and occupation; because legislation after 1930 provided for the admission of patients at an early stage of their illness; and because, relative to French asylums, English hospitals had more resources at their disposal and were in a better material condition. New approaches to patient occupation were adopted in English mental hospitals, while in France patient work did not evolve in the same way. In France, insufficient resources, in terms of both finances and staff; a management structure that compromised the authority of the CMO; and legislation that protected the *status quo*, impeded the adoption of these new approaches. These impediments were compounded by poor nursing standards and an adherence to an organicist interpretation of mental disorder by French psychiatrists, discussed in chapter three.

The more extreme economic constraints faced by French asylums following World War I, and the poor condition of asylums, led to a greater dependence on the financial benefits of patient work. Despite a series of articles appearing in the French professional journals during the late 1920s and 1930s recommending alternative models of patient occupation, and the existence of legislation in France designed to ensure that patient work was regarded as a means of treatment, the financial benefits to the asylum often took precedence over the therapeutic benefits to the patient. Financial priorities for patient work were perpetuated by the management structure of French asylums, according to which overall responsibility was divided between a head of administration (the Asylum Director or AD) and the Chief Medical Officer (or CMO). The AD, who controlled institutional finance, sought

to use patient work to keep maintenance costs down, compromising the CMO's ability to use occupation for purely therapeutic purposes. Patient occupation therefore became a contested area between the AD and the CMO, compromising its potential benefit to patients. This situation did not arise in English institutions where one medically qualified individual (the MS) oversaw all administrative and medical concerns and therefore had the authority to maintain a therapeutic agenda for patient work.

In England, from the early 1920s onwards, a pre-occupation with the economic benefits of patient work to the hospital was replaced by a focus on the therapeutic benefits to the patient. As a result, patient occupation was reconfigured in English mental hospitals, as new methods of OT were introduced, based on new models of patient occupation emerging overseas, particularly the USA. Adoption of OT became the hallmark of a truly modern hospital, according to the Board of Control, the organisation that oversaw provision for the mentally ill and the intellectually impaired in England and Wales. The move from patient work to OT, and from a policy of not occupying acute-stage patients, to one where OT was prescribed for patients at all stages of their illness, was partly prompted by British psychiatry's relative independence from other disciplines, and the accompanying ideological shift towards psychological methods of treatment; and partly by the experience of treating shell-shocked soldiers in World War I, which had demonstrated the benefits of occupation for the mentally disordered. It was also stimulated by the provision of separate care for curable and incurable cases; by a repudiation of the financial benefits of patient work in favour of occupation that was therapeutic; and by the introduction of legislation in 1930 that provided for the voluntary admission of patients to all public mental hospitals, resulting in greater numbers of early-stage, acute cases requiring active treatment rather than custodial care.

Part I: Infrastructure

4.1.1 Specialisation of Care

In England, the Mental Deficiency Act of 1913 provided for the separate care of the intellectually impaired ("mental defectives" in contemporary parlance) and the mentally ill.¹

¹ Mathew Thomson, "Disability, Psychiatry and Eugenics," in *The Oxford Handbook of the History of Eugenics*, ed. Alison Bashford and Philippa Levine (Oxford: Oxford University Press, 2010), 118.

The main purpose of the Act (for which the eugenics movement had lobbied) was the segregation of the intellectually impaired in order to prevent their reproduction, but a secondary objective was to relieve pressure on beds in mental hospitals, making space for curable cases. Specialist institutions, or “colonies”, for the intellectually impaired were to focus on care and self-sufficiency, while mental hospitals were to focus on providing medical treatment for curable cases.² Although provision of these specialist institutions was impeded by the financial restrictions brought about by the war and its aftermath, the government regarded “the working of the Act as essential to the physical and moral health of the nation”, and insisted that construction of the institutions continued.³ Patients who qualified for the new institutions were to be gradually transferred out of mental hospitals as colony accommodation became available, although as the MS of the Littlemore discovered, places were limited and did not admit the chronically ill or the elderly.⁴ While separate care for the intellectually impaired depended on local provision, in theory at least, efforts were being made to enable a focus on treatment, rather than custodial care, of the mentally ill.

In France, similar measures to separate incurable and curable cases of mental disorder were restricted to Paris, where asylum overcrowding was severe. Colonies were established in rural areas for incurable Seine patients at Dun-sur-Auron in 1892 and at Ainay-le-Château in 1897 at the instigation of Dr Auguste Marie (1865-1934).⁵ The Asile Clinique in Paris, discussed in chapter five, was transformed into a hospital for acute cases in 1927 (after decades of deliberation), resulting in the transfer of the Asile Clinique’s incurable patients to the colonies or provincial asylums. In France, therefore, there were also attempts to focus on acute cases, and the delivery of active treatment, but only in the capital. Admission as soon after the onset of acute symptoms as possible improved a patient’s chances of recovery, but early admission was impeded in both France and England by legislation concerning certification.

² Ibid.

³ Eighth Annual Report of the BOC, 1921, 2.

⁴ Littlemore Hospital Report, 1925/6, 10. OHA/L1/A2/3.

⁵ Michel Caire, “Armand Victor Auguste Marie,” in *Histoire de la Psychiatrie en France* (www.psychiatrie.histoire.free.fr/pers/bio/htm, 2014). (accessed 03/03/2018). See also: Juliet Rigondet, *Un Village Pour Aliénés Tranquilles* (Paris: Fayard, 2019).

4.1.2 Voluntary Admission

In France and in Britain until 1930 the very poor were unable to secure treatment for mental disorder in public asylums or mental hospitals outside their capital cities unless they had undergone the process of certification.⁶ Until 1930 in both countries, only patients whose conditions were certifiable according to the laws of 1838 (France) and 1890 (England) could be admitted to public asylums. The often-lengthy process of certification, which carried a social stigma, delayed the commencement of treatment thereby compromising the chances of recovery. Voluntary admission, which enabled patients to seek help at the early stages of their illness, before symptoms became severe and entrenched, was only possible at private asylums (*maisons de santé*) and medical faculty clinics in France and at private or registered mental hospitals in England. The effect of this policy was that the condition of many pauper patients, who might have made a recovery if treated earlier, became chronic and they ended up remaining in an asylum for long periods. From the point of view of patient work, this meant that public asylums contained a significant proportion of chronic patients for whom active treatment was deemed ineffective, but for whom work around the asylum provided a useful distraction (as well as providing the asylum with cheap labour).

Both Henry Maudsley in London and Édouard Toulouse in Paris recognised the need for the mentally ill poor to receive treatment without having to undergo the time-consuming and stigmatising legal commitment to an asylum or mental hospital.⁷ Toulouse had been campaigning to change the law of 1838 regarding access to treatment since 1899.⁸ In 1914, the law was almost revised to allow for voluntary admission to public asylums, but World War I broke out before the revisions were passed.⁹ In England, Maudsley was a “sharp and persistent critic” of the English system of lunacy legislation throughout his long career and was vehemently against the compulsory incarceration of the mentally ill.¹⁰ He envisaged patients passing through hospital for treatment, or remaining at home and receiving

⁶ The Maudsley Hospital (London) and the Henri Rousselle Hospital (Paris), which opened in 1923 and 1922 respectively, were the only public institutions accepting pauper patients on a voluntary basis.

⁷ Thomas, *Treating the Trauma of the Great War*, 149; Michael Collie, ed. *Henry Maudsley, Victorian Psychiatrist: A Bibliographical Study* (Winchester: St Paul's Bibliographies, 1988), 6-7.

⁸ Thomas, *Treating the Trauma of the Great War*, 148.

⁹ Henri Colin, “Mental Hygiene and Prophylaxis in France,” *Journal of Mental Science* Oct (1921):459.

¹⁰ Collie, ed., *Henry Maudsley, Victorian Psychiatrist*, 6.

treatment at an outpatients' department.¹¹ Attempts had been made to provide for the treatment of incipient cases of insanity in England through several parliamentary bills introduced between 1899 and 1905, but these bills had been withdrawn before becoming law.¹² Special dispensation was granted in 1915 to allow the Maudsley Hospital to accept voluntary patients, but this was not extended to any other public hospital. In 1920, another attempt was made to establish voluntary admission to all hospitals, but the Bill was defeated by the House of Lords, after being passed by the Commons.¹³ The MacMillan Report of 1926, following the Royal Commission tasked with investigating the claims of Dr Lomax, recommended voluntary admission and a focus on active treatment of incipient cases.¹⁴ The Mental Treatment Act of 1930, described by the BoC as "the outstanding event of the year", finally granted "the poorer classes" access to voluntary treatment.¹⁵ The BoC noted that "from the point of view of both humanity and of economy, treatment cannot begin too early".¹⁶ This Act enabled hospitals such as the Littlemore to admit voluntary patients; this gradually changed the acute/chronic profile of its patients, and, as a result, the nature of patient occupation, with acute cases (as well as previously unemployable chronic cases) receiving OT.

In France, Toulouse renewed his campaign for the provision of "open services" through the French League of Mental Hygiene, established in 1920.¹⁷ He obtained special dispensation to create the Service Libre de la Prophylaxie Mentale (SLPM) from the General Council of the Seine in 1922.¹⁸ This service, which enabled pauper patients to receive voluntary treatment, was unique in France for most of the interwar period. A proposal to extend the principle of voluntary treatment to all French departments was issued by the Ministry for Public Health in 1937.¹⁹ Had the proposal to create an "open service" been acted upon in La Sarthe, the patient profile of the ADLS might have undergone similar changes to those taking place at

¹¹ Ibid.

¹² Sixty-fourth (1909) Report of the Commissioners in Lunacy to the Lord Chancellor (London: HMSO, 1910), 32.

¹³ Fennell, *Treatment without Consent*, 107.

¹⁴ Report of the Royal Commission on Lunacy and Mental Disorder (London: HMSO, 1926), 19.

¹⁵ Sixteenth Annual Report of the BoC for the year 1929 (London: HMSO, 1930), 1.

¹⁶ Ibid.

¹⁷ Postel and Quétel, *Nouvelle Histoire De La Psychiatrie*, 351.

¹⁸ Ibid.

¹⁹ Marc Rucart, Ministère de la Santé Publique, Circulaire du 13/10/1937 relative à la ré-organisation de l'Assistance psychiatrique dans le cadre départemental, https://www.ascodocpsy.org/wp-content/uploads/textes_officiels/Circulaire_13octobre1937.pdf (accessed 20/11/2018).

the Littlemore after 1930. But, while the CMO of the ADLS was greatly in favour of establishing an “open service”, there was no space to build more pavilions within the hospital grounds and the existing hospital was already overcrowded.²⁰ There is no evidence of an “open service” being established at the ADLS; by the time the next annual report was issued for 1939, World War II had begun, putting any such plans on hold. The ADLS remained a “closed service” and did not receive uncertified, acute patients at the early stage of their illness before World War II. Unlike at the Littlemore, the ADLS did not experience an influx of acute patients; the patient profile remained the same and the patient workforce unaffected. Work continued to serve both as a distraction for chronic and incurable cases and as a means of offsetting institutional running costs.

4.1.3 Institutional Management Structures

In France, the sharing of responsibility for asylum management between the AD and the CMO could lead to tensions regarding the allocation of patient work between the two management teams. The departmental Prefect was supposed to settle any disagreements between the AD and CMOs, but neither the AD nor the Prefect were medically qualified. The AD of the Asile Clinique in Paris appointed in 1918, M. Reyrel, had been a cabinet minister at the Ministry of the Interior and was a former Prefect of the Seine.²¹ The structure was quite different to that of an English asylum, where decisions were taken, and both medical and financial priorities set by one person, a doctor. Patient work in French asylums was both a medical and an administrative concern, prescribed by CMOs as therapy for patients,²² and fulfilling an important financial role in controlling maintenance costs. As doctors Maurice Legrain (CMO of the Seine’s Villejuif Asylum) and Georges Demay (CMO of the Clermont Asylum in the Oise Department, northern France) wrote in a report commissioned in 1934 by the French government’s Superior Council for Public Assistance (published in *L’Aliéniste français* in 1936), “it is clear that patient work is regarded differently by the economic and technical services and by the medical services”.²³ They observed that for the Administration,

²⁰ Ibid.

²¹ Louis Dausset, Rapport Général au nom de la 3e Commission sur les propositions budgétaires pour le Service des Aliénés, CGS, 1918; 6. ADP/D.10K3/27/20.

²² Article 150, Circulaire du 20/03/1857, 75.

²³ M. Legrain et G. Demay, “Le Travail des Aliénés Convalescents”, *L’Aliéniste français* 12(1936), 283.

patient workers were divided into two groups, good workers and the rest, while for the medical team, productivity was not the main aim of the work.²⁴ Compared with their Dutch colleagues, as doctors Courbon and Porot observed, French doctors lacked authority. They were not respected, either by their staff or by the public and local authorities.²⁵ As Coffin has suggested, psychiatrists in the 1920s felt “under attack” because asylums were so overcrowded that it was difficult to provide any proper treatment.²⁶ A lack of respect was also a consequence of French psychiatry’s lack of independence as a separate discipline and the dearth of effective biological cures for mental disorder.

Édouard Toulouse was keen to avoid such conflicts and insisted on the role of “medical director” when appointed to run the SLPM in 1922, combining the functions of AD and CMO.²⁷ As Medical Director, he had control over both administrative and medical matters. Toulouse, like his English counterparts, could focus on the therapeutic aspects of work and occupation when prescribing it to patients. General Councillor Henri Rousselle noted in his 1923 report that patients “were not to be subjected to any work, but were recommended to occupy themselves”.²⁸ While work was available for patients (for which they would be paid), it was stated in the SLPM regulations that the sole aim of this work was therapy.²⁹ In other words, there was no obligation for patients to contribute to institutional running costs, but keeping busy was advised. While Toulouse, Mapother and Good still had to deliver a balanced hospital budget, their decisions were not constrained by the agenda of an AD who was not medically qualified and whose priority was management efficiency rather than treatment. Decisions made by the CMOs of the Asile Clinique and the ADLS regarding patient work were subject to negotiation with the asylum administration. As Demay highlighted in 1929, it was perfectly legitimate for the work carried out by patients to benefit the asylum and help reduce running costs, but the interests of the patients were always to take priority. The concepts of work-as-therapy (“*le travail-traitement*”) and work-

²⁴ Ibid.

²⁵ Courbon, “Un voyage d’études,” 403; Porot, “Van de Scheer et l’assistance,” 50-1.

²⁶ Coffin, “‘Misery and Revolution’,” 226.

²⁷ Édouard Toulouse, Rapport du médecin-directeur sur le Centre de prophylaxie mentale et l’Hôpital psychiatrique Henri-Rousselle, CGS, 1930, 65. ADP/D.10K3/46/78 Annexe.

²⁸ Henri Rousselle, Rapport au nom de la 3e Commission sur le Service départemental de prophylaxie mentale et les service annexes, CGS, 1923; 6. ADP/D.10K3/34/87.

²⁹ Article 28, Règlement du service départemental de prophylaxie mentale, dans M. Grangier, Rapport au nom de la 3e Commission sur le SLPM et les services annexes, CGS, 1925; 75. ADP/D.10K3/38/79.

for-profit (*"le travail-rendement"*) should not be mutually exclusive, but problems of interpretation could arise. A medical director, they argued, invested with both medical and administrative authority, would be able to balance the interests of patients and asylum management.³⁰

Hermann Simon, the originator of MAT, was also adamant that asylums should be medically directed to ensure that work was oriented towards a therapeutic rather than an economic goal.³¹ The matter of medical control of the asylum was also raised by Dr Ferrio in an article on the Law of 1838. Ferrio insisted that "the director of the psychiatric hospital must be a doctor, exclusively a doctor".³² This, he believed, was the only way of achieving harmony between all the various hospital services. Ferrio supported Toulouse's assumption of the role of both asylum director and CMO at the HRH, insisting that this was the only way forward.³³ Only a medical director had the authority to see through reforms and ensure the primacy of a therapeutic agenda. In England, where psychiatry was more professionalised, the MS, who was in sole charge of the hospital, had this authority.

4.1.4 Medical Superintendents and Chief Medical Officers

Unlike in France, where the CMOs were not in sole charge of their asylums, in England, although the MS was ultimately answerable to the local authorities (the County or Borough Councils), within the confines of the hospital he was "God", "the head man at the top" according to staff at Severalls Hospitals.³⁴ As the BoC highlighted in 1932, "the efficiency of a mental hospital depends more on the personality, the outlook and the experience of the Superintendent than on anything else".³⁵ They added that while administrative experience was important, professional acumen and breadth of medical knowledge were paramount. The MS was responsible for the general direction of the medical and scientific work and was

³⁰ G. Demay, "Les conditions de la thérapeutique par le travail dans les asiles," *L'Hygiène Mentale*, no. 2 (1929): 40.

³¹ Simon, "Le traitement des malades mentaux," 597.

³² Carlo Ferrio, "Le centenaire de la loi française du 30 juin 1838. Ce qu'en pense un étranger," *Annales Médico-psychologique* no. 1 (1939): 751.

³³ *Ibid.*, 752.

³⁴ Gittins, *Madness in Its Place*, 59-60.

³⁵ Nineteenth Report of the BoC, 1932, 9.

the “inspiration [behind] the real work of the hospital”.³⁶ In the USA, as Eleanor Slagle (one of the founders of AOT who worked with the influential psychiatrist, Adolf Meyer) observed, they had a saying that “a hospital or institution is but the lengthened shadow of its superintendent” and that the “ideals” of the latter were “reflected all along the line”.³⁷ In other words, the therapeutic approach of the hospital was set by the priorities of the MS. At the Littlemore, for example, Dr Good’s priority (following his experiences in World War I) was psychotherapy, which was complemented by OT.³⁸

In matters regarding most medical treatments (although not in the area of administration), French CMOs enjoyed a similar level of autonomy. But in the area of patient work, which impacted on the financial management of the asylum, the CMO’s authority was compromised by the AD. The management structure of French asylums remained unchanged by the legislation of 1937/8, so patient work continued to be a contested area between CMO and AD. That said, the many French asylum CMOs holding an organicist interpretation of mental disorder were unlikely to be impressed by the alleged benefits of OT for acute patients.

While French CMOs lacked the authority of their colleagues overseas, they were also overstretched. One doctor often had to care for 500-700 patients, which was excessive in Legrain and Demay’s view. They emphasised that if a doctor was to manage patient work effectively (or indeed any form of treatment), the number of patients under his control could not be this high.³⁹ At the ADLS, the CMO was responsible for 777 patients in 1929 and 899 in 1939 (despite the Circular of 1937), while at the Littlemore the MS was supported by medical officers and medical students. A breakdown of staffing levels at all six institutions is indicated in Tables 1 and 2 on pages 92-3. At the acute, metropolitan hospitals of the Asile Clinique, the Maudsley, Bethlem and the HRH, the ratios were far more favourable, as shown by Tables 3 a-f, on pages 94-5. Remarking on the situation in Holland, Paul Courbon noted that Dutch law imposed a limit of 125 patients per doctor.⁴⁰ At the provincial hospital of the ADLS, the CMO lacked the support of a medical assistant or interns, as Dr

³⁶ Ibid.

³⁷ Eleanor Slagle, “The Occupational Therapy Programme in the State of New York,” *Journal of Mental Science* Oct (1934): 641.

³⁸ Good, “History and Progress,” 605-7.

³⁹ Legrain and Demay, “Le travail des aliénés convalescents,” 283.

⁴⁰ Courbon, “Un voyage d’études,” 400.

Schultzenberger complained in 1934.⁴¹ Dr Christy was able to recruit a medical assistant in 1937, but without interns he was unable to carry out more labour-intensive treatments.⁴² With this sort of pressure on staff, it was unlikely that a new occupational regime could have been introduced. In any case, Dr Christy's priority for his curable patients was "aggressive biological treatment".⁴³

The CMOs who joined the ADLS in the 1930s, Dr Schultzenberger (CMO 1932-4) and Dr Christy (1934-9), both came from city institutions (the former from Paris and the latter from Lyon) where treatment methods were scientific. In his report to the Prefecture of 1933, Dr Schultzenberger complained about overcrowding, poor facilities, a lack of hygiene, old-fashioned treatment methods and understaffing.⁴⁴ The report was rejected by the Prefecture who insisted on his re-writing it. This he did, with a covering letter that made his views plain, and he left the ADLS the following year.⁴⁵ Dr Christy, appointed CMO in 1934, was keen to emphasise the "scientific principles" that guided his treatment methods (that involved "aggressive biological treatment" for acute patients), and to explain that he could only provide active treatment (that did not appear to include occupation) for the potentially curable. He felt this was justifiable since, from the point of view of the State, and considering the dearth of well-trained nursing staff to assist him, the cure of one young individual who could return to society as an active citizen was more economical than spending a great deal of time and effort treating the old and those unlikely to recover.⁴⁶ Other patients were merely overseen; in other words, they received the custodial care typically associated with "alienism".

⁴¹ Letter from Dr Schultzenberger to the President of the CDS, 12/12/1934. ADS/-1X261.

⁴² Rapport du Médecin en Chef, Hôpital Psychiatrique de la Sarthe 1937, 9. ADS/1X965.

[All French asylums became "psychiatric hospitals" in 1937 according to the Ministerial Circular of 13/10/1937].

⁴³ Rapport du Médecin en Chef, ADLS 1935, 7.

⁴⁴ Rapport du Médecin en Chef, ADLS (first version), 1933.

⁴⁵ Rapport du Médecin en Chef, ADLS (second version), 1933; letter from Dr Schultzenberger to the President of the Commission de Surveillance 12/12/1934.

⁴⁶ Rapport du Médecin en Chef, ADLS, 1935, 8.

4.1.5 Nursing Staff

Patient occupation was highly dependent on the quality of the nursing staff who spent the most time with patients on a daily basis. To a large degree, nurses' ability to supervise all but the most rudimentary form of occupation, required appropriate training, commitment to the role and empathy for patients (as noted in chapter three). It also depended on favourable staff-to-patient ratios (which depended on finances) and the ability of CMOs and MSs to attract quality staff. This in turn was affected by the pool of candidates from which they had to choose (evidently larger in the cities) and competition from other sectors of employment, which varied locally. Nurse recruitment was difficult in Le Mans, particularly following the introduction by the Popular Front government of the 40-hour week in 1937, which forced the CMO of the ADLS to more than double the number of nurses. Many of the new male members of staff had no experience of nursing and little interest in their work.⁴⁷

Nurse recruitment was not such a problem in England in the 1920s, but during the late 1930s, many English mental hospitals experienced difficulties in recruiting female probationer nurses. The problem appeared to affect both metropolitan and provincial institutions, including Bethlem and the Littlemore. In 1938, the shortage of junior nurses forced Bethlem's Physician Superintendent to recruit "eight foreign nurses".⁴⁸ In 1937, Littlemore's Dr Armstrong lamented, "It is a matter of anxiety and regret to many of us that so few girls nowadays enter the mental nursing service with the idea of making a career for themselves in this honourable profession".⁴⁹ Of those young women who did join the profession, many soon left to get married, or to take up appointments at other hospitals, or after realising that they were unsuited to the work.⁵⁰ One former nurse confirmed that female nurses were obliged to leave if they married.⁵¹ They were forbidden from going to the pub, and were only allowed to stay out late once a week, for which they had to apply for a "late pass".⁵² Selina Todd notes that young working class women preferred "any kind of a job" that offered "freedom" in preference to domestic service (although this remained the

⁴⁷ Rapport du Médecin en Chef, ADLS, 1937, 13.

⁴⁸ Report of the Physician Superintendent for the year ending 31/12/1938, Bethlem Royal Hospital, 20.

⁴⁹ Littlemore, Annual Report 1937/8, 12.

⁵⁰ Littlemore, Annual Report 1933/4, 12.

⁵¹ Interview with former female nurse, conducted by Jocelyn Goddard, 1994. The nurse began working at the Littlemore aged 17 in 1926. OHA/LH/OT232.

⁵² Ibid.

largest sector of employment for young women during the interwar years); they may have felt the same about mental nursing which incurred similar restrictions.⁵³ Hours and pay comprised additional disincentives to joining the mental nursing profession. In mental hospitals in the early 1930s, female probationer nurses were paid around 29 shillings per week, while a young woman working in a factory could earn £2-£3 per week, without the social restrictions of a hospital position.⁵⁴ A 60-hour week was the norm in 1932, although in 1935 this was reduced to 54 hours a week, including meal breaks.⁵⁵ Factory working hours had been restricted to 48 per week since 1919.

In France, secular female nurses were subject to similar unfavourable pay and conditions as their English counterparts, despite repeated efforts by the General Council to improve them between 1902 and 1913.⁵⁶ New career opportunities for young French women opened up after World War I, notably in the Seine department where increasing numbers of women began to perform work traditionally undertaken by men.⁵⁷ The number of women employed in metal-working trebled and female employment in the tertiary sector increased by some 300,000 jobs as women began to work in offices as typists, steno-typists and punch-card operators.⁵⁸ The emerging Parisian automobile industry offered a sociable environment for young women, and required little or no training.⁵⁹ Working with “*les fous*” suffered from a poor image; as Georges Daumézon remarked, very few young people held ambitions to become a mental nurse.⁶⁰ Factory work may have been far more appealing to young women and men than working in an asylum, which was looked down upon and involved working long hours in overcrowded, dilapidated conditions.

The introduction of new approaches to patient occupation required a plentiful supply of well-trained staff and the commitment of the MS or CMO. In France, it also required the co-operation of the AD, whose priority was ensuring that the asylum was financially viable. The

⁵³ Selina Todd, *Young Women, Work and Family in England, 1918-1950* (Oxford: Oxford University Press, 2005), 22.

⁵⁴ McCrae and Nolan, *The Story of Mental Nursing in British Mental Hospitals*, 93.

⁵⁵ Ibid.

⁵⁶ Henri Rousselle, “Rapport au nom de la 3e Commission sur les budgets et comptes de l’Asile Clinique,” *Conseil Général de la Seine* 1913, 3-4. ADP/D.10K3/24/39.

⁵⁷ Richard L. Zijdemann et al., “Working Women in France, Nineteenth and Twentieth Centuries. Where, When and Which Women Were in Work at Marriage?,” *The History of the Family* 19, no. 4 (2014): 552.

⁵⁸ Ibid.

⁵⁹ Fridenson, “Automobile Workers in France,” 516-8.

⁶⁰ Von Bueltingsloewen, *L'hécatombe Des Fous*, 266.

introduction of new methods that might compromise the contribution to the asylum budget made by patient work would be unwelcome in institutions where funds were limited. Institutions which had sufficient resources to enable them to disregard the financial contribution made by patient work were more likely to embrace the concept of OT. Local authority budgets in both France and England were very restricted after World War I, but the French economy had been particularly badly affected by the war and budgets were especially tight.

Tables 1 and 2: These tables show the staffing levels of the six institutions during the early 1920s and the 1930s indicating an increase over time in the numbers of medical and nursing staff, and the addition of new categories of staffing, such as psychologists, social workers and OTs. Unless otherwise stated, all staff were male. Female nurses at the ADLS were from the religious order of the Charité d'Evron; many were part-time to allow them to fulfil their religious obligations alongside their nursing duties.

Table 1: This table shows the staffing levels of the six institutions during the early 1920s.

	Asile Clinique (1922)	Henri Rousselle (1923)	Maudsley (1923/4)	Bethlem (1921)	ADLS (1919)	Littlemore (1926)
Patient Nos.	762 (380:382)	???	142 (65:77)	213 (87:126)	721	
Medical Staff	3 CMOs 7 Medical Assistants 1 Medical Intern 1 Dentist	1 MD 2 Medical Assistants 2 Medical Interns	1 MS 1 Deputy MS 2 Assistant MOs 5 Consultants for physical conditions	1 PS 3 MOs 1 Medical Assistant 1 Dentist	1 CMO	1 MS 2 Assistant MOs
Female Nurses	166	36 (gender not specified; some may have been attached to outpatient dept)	50	46	74 (many were part-time)	63
Male Nurses	150	?	12	38	34	47
Other staff involved in care of patients	1 Pharmacist 4 Pharmacy interns	1 Social Worker (female) Pharmacy staff attached to outpatients dept	1 Pharmacist 1 OT (from 1924; female) 1 Lady Almoner (female) 1 Chaplain	1 Pathologist 1 Pharmacist 1 Radiologist 1 Physio-therapist 1 Psychologist 1 Chaplain	No details	No details
Administrative Staff	1 AD 1 Bursar 23 office workers	1 Bursar 1 Clerk	3 Clerks	Various (not enumerated)	No details	No details
Domestic/ Technical/ Maintenance staff	96 (of whom 20 were female)	2 Kitchen staff	22 Domestic staff 3 Maintenance staff	Various (not enumerated)	No details	No details

Table 2: This table shows the staffing levels of the six institutions in the 1930s; few details were available for the Asile Clinique:

	Asile Clinique (1936)	HRH (1931)	Maudsley (1935)	Bethlem (1938)	ADLS (1937)	Littlemore (1937/8)
Patient Nos 1 Jan	829 (470:359)	182	216 (85:131)	224 (96:128)	869 (362:517)	865 (321:544)
Medical Staff	5 CMOs (following transformation of the service in 1928)	1 MD 4 Medical Assistants 4 Medical Interns	1 MS 1 Deputy MS 1 Clinical Director 12 Assistant MOs 4 Assistant MOs (inc 1 part-time female) 6 Consultants for physical conditions	1 PS 3 MOs 1 Medical Assistant 1 Dentist	1 CMO 1 Assistant Medical Officer (appointed in June) Various Interns for short periods of time	1 MS 2 Assistant MOs
Female Nurses	No details*	27 (gender not specified)	77	53	61	86
Male Nurses	No details*	?	17	42	141 (of whom 10 left during the year and 40 joined in July or later in the year #)	65
Other staff involved in care of patients	No details	2 Social Assistants (female) Pharmacy and laboratory staff attached to outpatient dept	2 Pharmacists 1 OT (female) 4 Social Workers + 2 training supervisors (female) 2 Psychologists 1 Chaplain 2 Masseuses (female)	1 Pathologist 1 Pharmacist 1 Radiologist 1 Physiotherapist 1 Psychologist 1 OT (from 1932; female) 1 Chaplain	1 Chaplain	No details
Administrative Staff	No details	1 Bursar/ Accountant 1 Clerk	8 Male Clerks 2 Female Clerks	Various (not enumerated)	1 AD 1 Bursar 1 Accountant 5 Office staff (incl. one female)	No details
Domestic/ Technical/ Maintenance staff	No details	4 Kitchen staff 65 General staff	39 Domestic staff 5 Maintenance staff	Various (not enumerated)	No details	No details

** An additional 34 nurses were recruited following the transformation of the Asile Clinique to an acute service in 1928.*

Nurse numbers were increased following the introduction of the 35-hour week in France in 1937 by the Popular Front government; three teams of nurses working 8-hour shifts were required instead of two teams working 12-hour shifts.

Tables 3a-f: These tables show the ratio of patients to nurses and doctors at each of the six institutions. Direct comparisons are complicated by the fact that precise shift patterns are unknown (e.g. whether the same number of nurses were on duty day and night); holidays and sick leave have not been taken into account.

Table 3a: Staff ratios at the Asile Clinique:

	1922
Patient Numbers (on 1 Jan)	762 (380:382)
Number of Nurses	194 (92:102)
Ratio of Nurses to Patients	1 : 4
Number of Doctors	10
Ratio of Doctors to Patients	1 : 76

Table 3b: Staff ratios at the Henri Rousselle Hospital:

	1931
Nos. Patients/beds	182
Number of Nurses	27
Ratio of Nurses to Patients	1 : 7
Number of Doctors	9
Ratio of Doctors to Patients	1 : 20

Table 3c: Staff ratios at the Maudsley Hospital:

	1923	1931	1935
Patient Numbers (on 1 Jan)	157	184	216
Number of Nurses	62	78	94
Ratio of Nurses to Patients	1:2.5	1:2.4	1:2.3
Number of Doctors	4	12	15
Ratio of Doctors to Patients	1:39	1:15	1:14

Table 3d: Staff ratios at the Bethlem Royal:

	1921	1929	1933	1938
Patient Numbers (1 st Jan)	213	196	207	224
Number of Nurses	84	79	95	95
Ratio of Nurses to Patients	1 : 2.5	1 : 2.5	1 : 2.2	1 : 2.4
Number of Doctors	5	5	5	5
Ratio of Doctors to Patients	1 : 43	1 : 39	1 : 41	1 : 45

Table 3e: Staff ratios at the Asile de la Sarthe:

	1919	1933	1937
Patient Numbers (1 st Jan)	721	812	869
Number of Nurses	71 (34:37*)	66 (2 teams)	202 (3 teams) @
Ratio of Nurses to Patients	1 : 10	1 : 12	1 : 5
Number of Doctors	1	1	2
Ratio of Doctors to Patients	1 : 721	1 : 812	1: 435

* Most female nurses from the religious orders were part-time; the figure of 37 full-time nurses is extrapolated from the 74 part-time nurses appearing in the records.

@ Additional nurses were recruited in 1937 to accommodate three shift system adopted after the introduction of the 35-hour week.

Table 3f: Staff ratios at the Littlemore:

	1926/7	1927/8	1931/2	1937/8
Patient Numbers (1 st January)	667	707	787	865
Number of Nurses*	88	86	89	130
Ratio of Nurses to Patients	1 : 7.5	1 : 8	1 : 9	1 : 6.5
Number of Doctors*	2	2	2	2
Ratio of Doctors to Patients	1: 334	1: 354	1: 394	1: 433

Part II: Resources

4.2.1 The Economic Consequences of World War I

The financial pressure caused by the war rendered the task of managing hospital budgets extremely difficult, while post-war inflation caused prices to rise unpredictably for essential items such as food. French losses during the war were particularly heavy; the industrial north-east of the country was occupied by enemy forces who laid waste to factories, towns and agricultural land as they retreated. 1.31 million Frenchmen were killed and 1.1 million were severely wounded with permanent work incapacity. France lost 7.2% of its human capital, 25% of its domestic assets and 49% of its overseas assets and 31% of its GDP was spent on the war.⁶¹ Inflation soared in the 1920s and remained an “uncontrollable nightmare” throughout the interwar period.⁶² The value of the French Franc fell from 25FF to £1 in 1914 to 200FF to £1 in July 1926.⁶³ Furthermore, 222,000 houses were destroyed; and 3 million hectares of land, half the road network, 1,800km of canals and 5,600km of railways needed repair or reconstruction. The damage was evaluated by the Reparation Committee at 34 billion Francs.⁶⁴

⁶¹ Jari Eloranta and Mark Harrison, "War and Disintegration, 1914-1950," in *The Cambridge Economic History of Modern Europe*, ed. Stephen Broadberry and Kevin O'Rourke (Cambridge: Cambridge University Press, 2010), 149.

⁶² Pilbeam, "Social and Economic Developments in Europe," 71.

⁶³ Ibid.

⁶⁴ Hautcoeur, "Was the Great War a Watershed?," 199.

Britain avoided the level of devastation experienced by France, although 715,000 British servicemen died and more than twice that number were wounded. Britain lost 3.6% of its human capital, 10% of its domestic and 24% of its overseas assets were destroyed, and over 25% of its GDP was spent on the war effort between 1915 and 1918.⁶⁵ Whilst healthcare budgets were strained in Britain, the severity of the French economic devastation resulted in even greater pressure being placed on public finances. The war increased the emphasis on the financial benefits of patient work as a means of offsetting institutional running costs in France. Depleted asylum finances not only influenced attitudes towards patient work but also affected the ability of institutions to recover from the material difficulties experienced during the war. In Britain, while the Board of Control encouraged economy in response to the straitened circumstances, there was no mention of trying to maximise the cost savings generated by patient work.

4.2.2 French and English Asylums in 1918

The condition of asylums in terms of facilities, financial resources and staffing all impacted on the ability of MSs and CMOs to introduce new methods of treatment, including new ways of organising patient work. Asylums in both France and England were in state of disarray following the cessation of hostilities in 1918. Many patients had been transferred to other asylums following the requisition of their original institutions by the military,⁶⁶ resulting in overcrowding in the establishments receiving the transferred patients.

Overcrowding, poor nutrition, fewer staff, lower standards of hygiene and the increased incidence of disease led to significant reductions in patient numbers, as a result of increased patient mortality, in both French and English asylums during the war.⁶⁷ The situation had been exacerbated by the influenza epidemic of 1918-19, which in France killed over 2,500 patients in the Seine department alone.⁶⁸ Those who survived were weak and

⁶⁵ Eloranta and Harrison, "War and Disintegration," 149.

⁶⁶ By the end of 1918, 17 out of the 97 public asylums in England and Wales were in use as war hospitals, including the Littlemore Asylum in Oxford and the Maudsley Hospital in London. Three out of the nine asylums of the Seine Department were requisitioned by the military, not including Ste Anne's.

⁶⁷ The number of individuals in care in England and Wales fell from 140,456 on 31/12/1914 to 116,703 on 31/12/1918, a reduction of 17%.⁶⁷ In the Department of the Seine, patient numbers fell from 15,919 on 31/12/1914 to 12,989 on 31/12/1918, a reduction of 18%. See: Dausset, "Rapport Générale," 1918, 20; Fifth Report of the Board of Control 1918 (London, HMSO: 1919), 25.

⁶⁸ Von Bueltingsloewen, *L'hécatombe Des Fous*, footnote 472.

undernourished. After the war, expenditure on health and welfare had to be tightly controlled as the French and English economies struggled to recover. While the BoC's report of 1918 indicates that the post-war condition of English asylums was poor, the General Council of the Seine's report, which included comments from the French Asylums' Medical Society (*la Société Médicale des Asiles*), suggest that French asylums were in an even worse state.

Despite a reduction in patient numbers caused by the war, the French Asylums' Medical Society predicted a return to the overcrowded conditions that had plagued the asylum system before 1914. They envisaged an increase in the incidence of mental illness amongst the general population whose resistance had been eroded by years of war-time privation and anxiety.⁶⁹ Asylum doctors felt that they lacked the tools to deal with the problem. They described the post-war state of the Seine asylums as "deplorable", with poor general hygiene; cramped, undifferentiated quarters; a lack of outdoor space; and poor facilities. Distractions, considered so important for patients whose conditions were beginning to improve, were practically non-existent.⁷⁰ Treatment for curable patients was compromised by the mixing of curable and incurable patients in the same quarters, and by ratios of 400 patients per doctor, resulting in most patients being merely "overseen" rather than receiving "modern" treatment.⁷¹ The Seine's asylums lacked the facilities for both laboratory testing (essential for the provision of a complete diagnosis) and research.⁷² Furthermore, most asylums lacked the equipment necessary for delivering modern treatments, such as hydrotherapy, UV-ray treatment, electrotherapy and radiography. Many patients, who, in more favourable conditions, might be cured or improved, remained in asylums far longer than was necessary. For those who were discharged, there were few means of support. Overall, the doctors claimed that services for the mentally ill were far behind those of "other great countries" and that French asylums were embarrassingly ill-equipped.⁷³

To address these shortcomings, Seine asylum doctors Édouard Toulouse, Henri Colin and Antoine Vigouroux, supported by the French Asylums' Medical Society, put forward

⁶⁹ Ibid., 26.

⁷⁰ Ibid., 27.

⁷¹ Ibid., 27.

⁷² Ibid., 27.

⁷³ Ibid., 28.

proposals for post-war improvements to the care of the mentally ill. In England, the Board of Control made similar suggestions. These proposals included the separation of acute, recent cases of mental illness and chronic patients; an admissions system for recent or incipient cases of mental illness to asylums or mental hospitals that avoided the usual legal formalities; improvements to the support available for recently discharged patients; and improvements to the training, pay and conditions of asylum staff.⁷⁴ In France, Dr Toulouse advocated the establishment of a League of Mental Hygiene to co-ordinate the efforts of doctors, administrators and council officials in orchestrating these reforms.⁷⁵ Cost-savings could be made, it was suggested, by taking steps to enhance the economic value of patient work, and by providing separate care for chronic patients, who did not require intensive medical treatment or specialist facilities.⁷⁶

The difficulties experienced by French asylums in 1918, and the recommendation, welcomed by the General Council, that patient work could be made to further contribute to institutional running costs, suggest that an economic rationale for patient work took precedence over a therapeutic rationale. There was no encouragement by the Board of Control to increase the financial contribution made by patient work in English asylums. In fact, the economic benefits of patient work were downplayed in England. The French asylum system would have been greatly improved by adoption of the recommendations made by the Asylums' Medical Society, but the situation in the majority of French asylums only appeared to worsen. As Isabelle von Buelzingsloewen emphasises, overcrowding continued to blight French asylums throughout the interwar period.⁷⁷ This was due to the number of long-stay, incurable patients as well as to increasing numbers of admissions.⁷⁸ The overcrowding led to a deterioration of living conditions and a reduction in the amount of care received by each patient.⁷⁹ The problem of overcrowding remained especially acute in the Seine department, despite the existence of six asylums in the department and the policy of sending a certain number of patients each year to provincial asylums. The situation

⁷⁴ Dausset, "Rapport Général," 1918, 20-3, ADP D.10K3/27/20; Fifth Report of the BoC 1918, 1-4.

⁷⁵ Dausset, "Rapport Général," 1918, 23, ADP D.10K3/27/20.

⁷⁶ Ibid., 43. Separate care for chronic patients was already available in the Seine department; colonies at Dun-sur-Auron and Ainay-le-Château had been established in 1892 and 1898 respectively.

⁷⁷ Von Buelzingsloewen, *L'hécatombe Des Fous*, 252-8.

⁷⁸ Ibid., 253.

⁷⁹ Ibid., 253-4.

was so severe, that plans for a seventh asylum with a capacity for 1,600 beds, discussed before 1914, were resurrected in the 1930s.⁸⁰ Although staffing levels varied between departments and between asylums, in general the increased numbers of patients did not translate into an increase in the number of medical and non-medical staff; French asylums outside Paris remained understaffed, as will be demonstrated in chapter six. In 1937 Marc Rucart, Health Minister, admitted that mental health had not received sufficient attention since the end of World War I because the government had been focused on the problem of tuberculosis.⁸¹ The neglect of French asylums did not produce auspicious conditions for the introduction of new methods of patient occupation.

4.2.3 Conclusion

Even if French asylum CMOs had been ideologically disposed towards psychological methods of treatment, such as occupational therapy, they lacked the authority to change the emphasis of patient work from its economic benefits to the institution and towards the delivery of more therapeutic benefits for patients. This was the result of a management structure, set out in the legislation of 1838, that established shared responsibility for asylum management with the AD. French CMOs lacked the authority of their English counterparts, who were in sole charge of their establishments and commanded great respect (at least within the hospital walls). Like in the US, the treatment preferences and *modus operandi* of the English MS percolated through to the whole mental hospital, so if the MS saw fit to introduce OT, everyone else would fall in line. French CMOs were also having to deal with overcrowding, poor facilities, impossible staff-to-patient ratios, badly trained nursing staff and a lack of government support. Furthermore, their training and professional heritage did not predispose them towards an interest in OT, particularly not for acute patients. The legacy of the revered French psychiatrist, Valentin Magnan (head of the prestigious Admissions Service at Ste Anne's from 1867 to 1912), who insisted on bed-rest for acute patients, sometimes for several weeks, was hard to dispel. That said, there were some French psychiatrists who took a different view and were keen to see OT introduced into French asylums. Their efforts to bring this about are discussed in the next section.

⁸⁰ Ibid., 257.

⁸¹ Rucart, Circulaire du 13/10/1937.

Part III: New Approaches to OT

4.3.1 Introduction

In France, certain psychiatrists (most notably those based in Paris) were keen to promote the German method of OT, known as “More Active Therapy” (or MAT), but their advice was largely ignored by the CMOs of French asylums. Four main reasons can be cited to explain their reluctance: their organicist stance (that led the majority of psychiatrists to prefer biological methods of treatment); poor quality nursing staff; management issues, which, as demonstrated in part I of this chapter, created conflict between CMOs and ADs; and financial pressures (leading ADs to fear that new methods of occupation might threaten the economic contribution made by existing systems of patient work). In England, ideas regarding occupation emanating from the USA were well received by psychiatrists, particularly amongst those who adopted the psychobiological approach of the American psychiatrist, Adolf Meyer, a keen advocate and practitioner of OT. The German method, MAT, was also promoted by the Board of Control, but knowledge regarding this method arrived later and did not generate the same level of enthusiasm. Higher nursing standards, a better financial situation, and a management structure that conferred responsibility for the hospital on one MS, all contributed to creating an environment that was more receptive to new therapeutic approaches to work.

4.3.2 Patient Work in the Nineteenth Century

Work had been used in asylums as a form of therapy since the early nineteenth century when it formed an essential element of “moral therapy”. Pioneers of moral therapy, Philippe Pinel in France and William Tuke in England each advocated a balanced regime of work, recreation and rest for patients. However, by the mid-nineteenth century, overcrowding took its toll on the provision of moral therapy, the efficacy of which began to be questioned. Moreover, once it became a legal requirement that asylums had a resident medical officer, according to the terms of the Lunacy Act of 1845, the treatment of patients became less oriented towards psychological methods of treatment.⁸² This trend was further enhanced by Morel’s theory of hereditary degeneration, that led to a greater focus on the physiology of mental disorder. That said, the basic principles of moral therapy, which

⁸² Digby, "Moral Treatment at the Retreat," 67.

emphasised the importance of the asylum environment, a regular routine, nutritious food and the provision of exercise and occupation in the form of work and recreation, continued. Asylums were still being built according to these principles until well into the twentieth century, with the asylum grounds considered an important therapeutic tool.⁸³ The Code of Practice within asylums, which had been drawn up in 1827 and included guidance on the provision of occupation, still pertained. Work took on a more functional guise, however, with patients deployed to assist with the management of the institution. Patients worked on the asylum farm or market garden, in the laundry or kitchen, in the various workshops, in the grounds, or on the wards. These activities were deemed to complement, rather than compromise, other forms of medical treatment. Furthermore, there were no *effective* medical treatments for mental disorder (apart from GPI) until the 1930s, so the provision of occupation was at least something that could be done for patients at the same time as benefitting the institution.

The Lunacy Commission of England and Wales expected Medical Superintendents to record how many patients were “usefully employed” and in what capacity, a practice that continued until 1914 when the pressures of war made the recording of such statistics superfluous. In France, although the law of 1838 (reinforced in 1857) stipulated that “Work is instituted in the establishment as a means of treatment and distraction for patients”, patient work fulfilled a vital economic function.⁸⁴ As Dr Auguste Marie reminded asylum managers in 1906, “the main purpose of work in asylums is the well-being of the patients; its usefulness as a means of production should be entirely subsidiary.”⁸⁵ By the outbreak of World War I, patient work had therefore been a persistent feature of asylum regimes for over one hundred years. While its value as a therapy had become overshadowed by institutional requirements during the latter part of the nineteenth century, the practice of patient work nevertheless continued despite psychiatrists’ turning away from psychological modes of treatment in both Britain and France.⁸⁶

⁸³ Clare Hickman, *Therapeutic Landscapes: A History of English Hospital Gardens since 1800* (Manchester and New York: Manchester University Press, 2013), 72, 103.

⁸⁴ Article 150, Circulaire du 20/03/1857, 75. www.gallica.bnf.fr (accessed 03/12/2017).

⁸⁵ M. Navarre, “Rapport au nom de la 3e Commission sur les propositions budgétaires pour le service des Aliénés (budget de 1907),” *Conseil Générale de la Seine*, 1907. ADP/D.10K3/17/41. [Dr Marie was at this time a CMO at the Villejuif Asylum in Paris.]

⁸⁶ Laws, “Crackpots and Basket-Cases,” 69.

4.3.3 Legislation regarding Patient Work and Distractions

France was the only country in Europe where there existed legislation regarding patient work within the context of asylum management; there was no such legislation in England; the Code of Practice advocating occupation drawn up in 1827 was not legally binding. French legislation pertaining to all aspects of asylum management, including patient work, had been created in 1838 and amended in 1857, and applied to all “closed” asylums, both provincial and metropolitan. By the 1930s, the law of 1838 was considered outmoded. Many psychiatrists called for a complete reform of the law, which attracted considerable criticism at the 1937 International Congress for Mental Hygiene in Paris.⁸⁷ The Ministerial Circular of 1937 was a partial response to these demands. As well as the creation of “open services”, departmental prefects were asked to consider the establishment of psychiatric dispensaries, or outpatient facilities, offering consultations outside the asylum; the introduction of a social service, staffed by specialists; the provision of assistance for “abnormal children”; and the promotion of patronage societies to assist patients post-discharge.⁸⁸ The implementation of all of these measures would have brought services in the provinces more in line with those offered in the capital by the SLPM. At the SLPM, the emphasis was on enabling patients to work *outside* the hospital, following recovery or whilst continuing to receive treatment, rather than *inside* an institution. Prefects were also asked to oversee the modernisation of services within the “closed” asylum, such as taking steps to limit the number of patients for whom doctors were responsible to 400, ideally 200, to allow the delivery of active medical treatment.⁸⁹ The CMO of the ADLS found these changes impossible to implement straight away and in 1939, World War II intervened.

Amendments to the law of 1838, instituted in 1938, altered only slightly the existing legislation pertaining to the organisation, staffing and the daily routine in “closed” asylums, including patient work and distractions. It did not deliver the complete overhaul of the asylum system that many psychiatrists had sought.⁹⁰ There were few changes to the

⁸⁷ G. Heuyer, “A propos de la loi de 1838 et de son projet de révision,” *Annales Médico-psychologique* 2, no. 7 (1939): 219-240.

⁸⁸ Rucart, Circulaire du 13 Octobre 1937, 35.

⁸⁹ Ibid.

⁹⁰ The law of 1838 was only replaced in 1990; until then any changes to the regulations were made by a series of amendments. See: Pauline Rhenter, “La Réforme Des Hospitalisations Psychiatriques Sans Consentement: Un Éclairage Historique,” *Journal français de psychiatrie* 3, no. 38 (2010): 12-15.

regulations regarding patient work. Article 171 re-stated that “work is instituted in the establishment as a means of treatment and distraction for patients” and that “the CMO alone decides which patients should work and the type of work they are able to do”.⁹¹ While the wording of article 171 clearly stressed the therapeutic role of patient work, which had been recognised since the early nineteenth century, article 175 maintained that the product of the patients’ labour belonged to the institution.⁹² Although the CMO prescribed work for patients, the AD’s involvement was indicated by article 173 which stated that the CMO should inform the AD approximately how many patients would be available for work.⁹³ So the revised legislation did not help to clarify the situation *vis à vis* the therapeutic and economic objectives of patient work, which remained a contested area. The type of work considered suitable for patients, unchanged from 1857 and aimed at satisfying institutional requirements, included market gardening, sewing, work in the laundry, ironing, maintenance work, work in the various workshops, terracing and building, and agricultural work.⁹⁴ The length of the working day for patients was reduced from ten to eight hours, in line with legislation for work outside the asylum (article 176). As before, patients were to be paid for their work at a rate set by the AD with the agreement of the CMO. An increase in the minimum rate of the *pécule*, fixed at 0.50F per day, and that of the *pécule de sortie*, at no less than 25F, reflected the increased cost of living.⁹⁵

In terms of distractions, the circular re-iterated that patients should be entitled to “intellectual occupations” and distractions, either on a group or individual basis. These might include games, walks, parties or sport. It was re-iterated that patients were forbidden from playing games for money (article 186).⁹⁶ As before, patients were to be given a monthly allowance of tobacco, at the discretion of the CMO (article 187). New in 1938 was the obligation to provide a library for patients (article 189). This may have been in response to criticisms regarding the poor provision of reading material in asylums. Ladame and Demay had observed in 1926 that while it was highly desirable for asylums to provide

⁹¹ Marc Rucart, Ministère de la Santé Publique, Circulaire Ministérielle du 5 février 1938 – Règlement modèle du service intérieur des hôpitaux psychiatriques et son annexe, http://www.ascodocpsy.org/wp-content/uploads/textes_officiels/circulaire_5fevrier1938_annexes.pdf (accessed 20/11/2018).

⁹² Ibid.

⁹³ Ibid., 69.

⁹⁴ Ibid., 69.

⁹⁵ Ibid.

⁹⁶ Ibid., 71.

newspapers, books and games for patients, many did not.⁹⁷ Paul Wahl raised the matter again in 1935. Reading, he emphasised, was very important for patients, but material had to be of a suitable type and should therefore be selected by the medical team.⁹⁸

The Circular of 1938 highlights several similarities and differences between the French and English approaches. In both France and England, work was to be for the benefit of patients and medically prescribed, a principle established by the early nineteenth-century moral therapists. This point is particularly interesting in the case of the Asile Clinique, where patient work was so essential to the smooth-running of the institution that chronic patients had to be drafted in to carry out work that acute patients were deemed incapable of performing.⁹⁹ It seems that although the principle of work as benefiting patients was upheld in both countries, there was more difference in practice. On the topic of remuneration, French patients were paid a daily amount for their work, while English patients worked without pay, even though payment had been recommended by the Cobb Report in 1922.¹⁰⁰ English patients did not receive a lump sum on discharge from the asylum, which their French counterparts had earned through working, nor did they receive a monthly allowance of tobacco. The type of work that was indicated as suitable for patients in the French legislation was essentially the same as that given to English patients, prior to the introduction of OT in England in the early 1920s. English and French hospitals offered similar types of entertainment and distractions. Occupational therapy, as opposed to patient work, was not mentioned in the amended French legislation of 1938, despite the recommendations of MAT made by some French psychiatrists in the professional journals throughout the preceding decade. On the one hand, the introduction of MAT would have required significant re-organisation, more highly trained nursing staff to supervise the activities, and a potential loss of revenue from patient work. On the other hand, the majority of asylum psychiatrists were organicists who prioritised biological interventions over the alleged therapeutic benefits of OT for acute patients and only considered patient work beneficial for chronic and convalescent patients.

⁹⁷ Ladame and Demay, *La thérapeutique*, 18.

⁹⁸ Paul Wahl, "Distractions et travail intellectuel dans les Asile d'aliénés," *L'Aliéniste français* 1 (1935):135.

⁹⁹ Procès-Verbal de la Séance 6/11/26, CDS des APS, 240. ADP/D1X3-42/3.

¹⁰⁰ Ministry of Health. Report of the Committee on Administration of Public Mental Hospitals (London: HMSO, 1922), 53-4.

4.3.4 Criticisms of Patient Work in the 1920s

After World War I, the provision of patient work in French asylums was criticised by certain psychiatrists who believed that it was not being used to its full therapeutic potential. Julien Raynier (1888-1936) and Henri Beaudouin (1885-1968) were awarded the Prix Baillarger for their publication *L'Aliéné et les Asiles d'Aliénés au point de vue administrative et juridique* (1924), which became known as the “bible” for asylum doctors.¹⁰¹ The authors maintained that patient work was neglected or poorly organised in many asylums.¹⁰² Their views were influential because Raynier had served on several professional commissions of the Superior Council of Public Hygiene, and was eventually appointed inspector general of administrative services for the Ministry of the Interior in 1935.¹⁰³ Beaudouin, renowned for his clinical skills and reformist agenda, became an asylum doctor in 1920 and was appointed CMO of the Maison Blanche, Paris, in 1926, where he remained until his retirement in 1955.¹⁰⁴ Raynier and Beaudouin maintained that CMOs should not need reminding of the contribution made by work to a patient’s mental and physical well-being, as this had been accepted since the early nineteenth century.¹⁰⁵ They highlighted the therapeutic benefits of patient work for all patients, particularly farm work (which also provided the asylum with nutritious, fresh food), and lamented its absence from many asylums.¹⁰⁶ Work, they maintained, accelerated convalescence from acute psychosis and provided an excellent treatment for chronic patients.¹⁰⁷ The authors identified several possible reasons for asylums not providing sufficient work for patients, including availability of cultivable land, problems with supervising patients, an unwillingness to participate by patients unaccustomed to the type of work available, or simply preferring to be idle. Whatever the reason, Raynier and Beaudouin urged the CMOs to address the problems, either by buying or renting land, establishing indoor workshops, or by extending the range of available work.

¹⁰¹ Michel Bénézech, “Une Bible Oubliée De La Pratique Psychiatrique Asilaire : Le Traité Des Docteurs Raynier Et Beaudouin (1924, 1930, 1949–1951),” *Annales Médico-psychologiques, revue psychiatrique* 171, no. 1 (2013): 52.

¹⁰² J. Raynier and H. Beaudouin, *L'Aliéné et les Asiles d'Aliénés au point de vue administratif et juridique, assistance et législation* (Paris, Librairie Le François: 1924), 298. A second edition of their work appeared in 1930 and became the acknowledged reference work for all those working in the asylum system.

¹⁰³ Bénézech, “Une Bible Oubliée,” 52.

¹⁰⁴ Ibid.

¹⁰⁵ Raynier and Beaudouin, *L'Aliéné*, 312.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid.

Raynier and Beaudouin emphasised that it was the CMO's duty to explain to the personnel directing the patients' work that patients should not be expected to be as productive as "normal individuals" and that the purpose of the work was therapy. Among the benefits, a patient gained "social dignity" through productive work, even if s/he was only able to achieve minimal results.¹⁰⁸ Some doctors (including Dr Marie of Ste Anne's) wanted workshop managers to undergo training. Raynier and Beaudouin realised that this was impractical, but they urged doctors to give clear instructions and advice.¹⁰⁹ It was important that those supervising patient work were capable of teaching the work to patients and of setting a good example by doing the work themselves.¹¹⁰ Raynier and Beaudouin focused on improving how work should be conducted according to the regulations of 1857; they were not advocating new methods from abroad. From 1926 onwards, new ideas were advanced by French psychiatrists aiming to rejuvenate patient work in French asylums.

Meanwhile, in English mental hospitals, the MS was responsible for allocating work to patients but was not obliged by law to provide it. Whether or how much work was provided for patients, depended on the "the extent to which the MS...takes a real and lively interest in these matters so essential to the care and treatment of the insane" as the Lunacy Commission observed in 1910.¹¹¹ In some cases, they noted, provision was minimal.¹¹² After World War I, criticism of the way employment was organised in mental hospitals was stimulated by an incendiary book by Dr Montagu Lomax, entitled *Experiences of an Asylum Doctor*, published in 1921. The book was based on the two years Dr Lomax spent working at Prestwich Mental Hospital and criticised, among many other aspects of asylum administration, the provision of patient work, recreation and exercise. The book caused a public outcry and prompted an inquiry by the Ministry of Health, led by Sir Cyril Cobb.¹¹³

Lomax deplored the type of work given to patients, the conditions of work and the fact that patients were not paid for their work. He noted, for example, that a dozen male patients were employed in the coir-picking workshop, picking the coconut fibre used to stuff patient mattresses: "It is unpleasant, unhealthy work, reminiscent of oakum-picking to those who

¹⁰⁸ Ibid., 313.

¹⁰⁹ Ibid., 313.

¹¹⁰ Ibid., 314.

¹¹¹ 64th Annual Report of the Lunacy Commission, 1910, 31.

¹¹² Ibid.

¹¹³ Jones, *Asylums and After*, 128.

have been in jail or worked as ‘casuals’ in workhouses”.¹¹⁴ The dust generated by the activity was dangerous for patients suffering from bronchitis or other chest conditions. Lomax remarked that this type of work was “very useful” for the asylum authorities as it saved “much expense”.¹¹⁵ The “closet-barrow gang” were allocated the unenviable task of emptying the asylum’s commodes, described by Lomax as the “most unpleasant and unhealthy work of all”.¹¹⁶ The task had to be performed in all weathers and occupied the “gang” for four to five hours a day with only a half-hour break for breakfast that had to be eaten outside. It would not have been so bad if the patient workers had been “well fed, well clothed and properly compensated”, but this was not the case.¹¹⁷ The asylum farm employed 35 patients, most of whom were “chronic demented”, supervised by the farmer and three or four attendants. Lomax’s criticism of the farm was not the work performed by patients, but the nature of what was produced. The farm could have grown a much wider variety of fresh produce that would have benefited the patients’ dietary. Fresh fruit and vegetables (for which the land was suitable) would have provided much-needed vitamins and added variety to “the eternal round of bread, bully-beef, pork, bacon, potatoes, sprouts and dried peas”.¹¹⁸

Following these allegations, the Cobb Report concluded that with regard to Prestwich Hospital “there was room for considerable development in organising the occupation of patients, both as regards the number of patients employed and the variety of work undertaken”.¹¹⁹ Commenting on patient work more generally, Cobb noted that 56.9% of mental hospital patients were “usefully employed” but that over half were engaged in ward work.¹²⁰ This was an area for improvement, although Cobb noted that in some of the newer mental hospitals, which were equipped with modern workshops, a “remarkable range of work” was undertaken.¹²¹ Cobb agreed that patients should receive some sort of remuneration, which would offer an “incentive to work” and would stimulate the patient’s

¹¹⁴ Lomax, *The Experiences of an Asylum Doctor*, 104.

¹¹⁵ *Ibid.*

¹¹⁶ *Ibid.*, 106.

¹¹⁷ *Ibid.*

¹¹⁸ *Ibid.*, 116.

¹¹⁹ Report of the Committee on Administration of Public Mental Hospitals, Ministry of Health (London: HMSO, 1922), 51-2.

¹²⁰ *Ibid.*, 52.

¹²¹ *Ibid.*, 52.

self-respect.¹²² He also agreed that more should be done to “promote social life” than was currently afforded by the weekly entertainments, and that patients should be provided with more opportunities for parole and exercise.¹²³

No doubt prompted by the Cobb Report, the Board noted, in its annual report of 1923, that “the organisation of occupations in most hospitals is not altogether satisfactory” and that “the number of patients of both sexes whose only employment is ward work is noteworthy”.¹²⁴ The commissioners remarked, “We attach so much importance to occupation as a curative agent and as a means of promoting the contentment and well-being of patients that we should like to see the organisation of industries placed upon a better footing, possibly by the appointment of an Occupations Officer.”¹²⁵ They observed that an Occupations Officer had been appointed at the recently-opened Maudsley Hospital, where provision had been made for occupation and recreation, such as carpentry, gardening and tennis.¹²⁶ A Royal Commission on Lunacy and Mental Disorder, ordered to further investigate Lomax’s claims, conducted its inquiries between 1924 and 1926.¹²⁷ The resulting Macmillan Report of 1926 indicated that further facilities for occupation and amusement should be provided and that the appointment of an occupations officer should be considered.¹²⁸ The findings of the Cobb and Macmillan Reports coincided with the arrival of new ideas regarding patient occupation from the USA, and would ultimately lead to a divergence in approaches to occupation in England and France.

4.3.5 New approaches to Occupational Therapy

Neither the American versions of occupational therapy (AOT) nor the German version, known as “More Active Therapy” (MAT), were entirely “new”. It has been suggested by historians of medicine, Gerald Grob and Marijke Gijswijt-Hofstra that both the new methods of occupational treatment bore significant resemblances to early nineteenth-century moral

¹²² Ibid., 52.

¹²³ Ibid., 55.

¹²⁴ Tenth Report of the Board of Control 1923:10.

¹²⁵ Ibid.

¹²⁶ Ibid, 29.

¹²⁷ Jones, *Asylums and After*, 130.

¹²⁸ AU, “Royal Commission on Lunacy and Mental Disorder: Summary of Report, *The British Journal of Nursing* (September 1926): 201.

therapy.¹²⁹ AOT was also moulded by the Arts and Crafts Movement, the Work Cure and the Mental Hygiene Movement. AOT developed out of the collective vision of individuals from a variety of backgrounds including psychiatry, nursing, social reform and the arts, who all believed in the therapeutic value of occupation. The National Society for the Promotion of Occupational Therapy (NSPOT) was formed in 1917, on the eve of the USA's entry into World War I. A key figure involved in NSPOT from its inception was the psychiatrist Dr Adolf Meyer (1866-1950), whose "psychobiological" approach to psychiatry included re-education through occupation. Meyer recognised that occupation could be used to help individuals solve problems of adaptation to their environment, which he regarded as one of the main causes of mental disease.¹³⁰

MAT was developed by just one individual, Dr Hermann Simon (1867-1947), who was appointed medical director of the Warstein Asylum in 1905 and the Gutersloh Asylum in 1919. MAT was based on the belief that idleness was the "root of all evil". Simon maintained that "Idleness is the beginning not only of all vice, or antisocial tendencies, ... but also of impending idiocy".¹³¹ Both the new approaches involved the re-education of the patient through the establishment of a regular routine of occupation, rest and recreation. They differed in the type of occupation that patients were expected to perform. The activities involved in MAT were based on the "real work" required to run the institution, while AOT was focused on the teaching of arts and crafts to patients. These were deemed to stimulate the patient's interest, engage them in the creative process of making something aesthetically pleasing, and instil a sense of pride in their achievement.

4.3.6 The American Model of Occupational Therapy (AOT)

Originally trained as a neurologist in Switzerland, Meyer became interested in psychiatry and psychology while visiting hospitals in Edinburgh and London. On emigrating to the USA in 1892, his initial appointment was as pathologist to the Kankakee Asylum, just outside

¹²⁹ Marijke Gijswijt-Hofstra and Harry Oosterhuis, "Introduction: Comparing National Cultures of Psychiatry," in *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, ed. Marijke Gijswijt-Hofstra, et al. (Amsterdam: Amsterdam University Press, 2005), 46. Gerald N. Grob, "Pathologist of the Mind: Adolf Meyer and the Origins of American Psychiatry by S. D. Lamb (Review)," *Bulletin of the History of Medicine* 89, no. 3 (2015): 618.

¹³⁰ Adolf Meyer, "The Philosophy of Occupational Therapy," in *The Collected Papers of Adolf Meyer*, ed. Eunice Winters (Baltimore: Johns Hopkins Press, 1952), 86.

¹³¹ Ankele, "The Patient's View of Work Therapy," 241.

Chicago. Critical of clinical practice at Kankakee, asylum reform became one of Meyer's goals.¹³² His appointment as the first director of the new psychiatric clinic, the Henry Phipps Clinic at the Johns Hopkins University Medical School in Baltimore, which opened in 1913, gave Meyer a position of great influence and a platform from which to share his ideas and train younger doctors.¹³³

Meyer, a founder member of the American Mental Hygiene organisation, outlined his philosophy of occupation at the fifth annual meeting of NSPOT in 1921; this paper was published in the American *Archives of Occupational Therapy* and reviewed in the British *Journal of Mental Science* in 1922. Meyer explained that when he first began working in the American asylum system in the 1890s, he observed that patients were engaged in work in the laundry, kitchen, industrial workshops and on the wards, but the work was "very largely planned to relieve the employees". Little was done to "foster [the patients'] interest in occupation".¹³⁴ Here Meyer was articulating the difference, as he saw it, between patient work and occupational therapy. He noted how readily patients responded to a simple programme of craft activities, taking "a pleasure in achievement, a real pleasure in the use of and activity of [their] hands and muscles, and a happy appreciation of time".¹³⁵ Meyer believed that "the main advance of the new scheme was the blending of work and pleasure" and the fact that the activities were organised according to their appropriateness for individual patients, rather than part of an overall, centralised scheme of work.¹³⁶

Meyer maintained that "the proper use of time in some helpful and gratifying activity" was fundamental to the treatment of the neuropsychiatric patient.¹³⁷ He claimed that physicians and nurses needed to prioritise the "systematic engagement of interest, and ... the actual use of time and work" since "problems of living" and "habit deterioration" were the root causes of so many mental disorders.¹³⁸ People needed to achieve a balance between sleeping and waking, hunger and its gratification, and work and play. Meyer felt that the

¹³² Michael Gelder, "Adolf Meyer and His Influence on British Psychiatry," in *150 Years of British Psychiatry 1841-1991*, ed. German Berrios and Hugh Freeman (London: Gaskell, 1991), 423.

¹³³ *Ibid.*, 424.

¹³⁴ Meyer, "Philosophy of Occupational Therapy," 87.

¹³⁵ *Ibid.*

¹³⁶ *Ibid.*, 88.

¹³⁷ *Ibid.*, 86.

¹³⁸ *Ibid.*, 88.

only way to achieve this was by “*actual doing, actual practice*”.¹³⁹ It was important for patients to have an orderly day during which they were engaged in a balanced programme of rest, play, exercise and satisfying activities. These activities should make the patient feel that the effort had been worth-while and the time well spent. The occupation should be designed so that a finished product could be completed in just a few sessions to a standard that gave the patient a sense of achievement and pride. Patients needed to be given appropriate opportunities to be creative and to learn to use different materials, and it was up to the therapist to identify the sort of activities that might appeal to individual patients. Through performing these activities, patients learned how to organise their time and make the best use of the opportunities available to enable them to achieve their goals.¹⁴⁰ The patient should not participate in OT to satisfy the therapist or physician, but because they genuinely wanted to achieve some “concrete results” from the activity.¹⁴¹ The therapist should aim to inspire confidence in the patient and to foster their interests and capacity for achievement.¹⁴²

One of the earliest programmes of occupational therapy, based on habit training, was established at the Henry Phipps Clinic, under Meyer’s direction, in 1913.¹⁴³ The daily routine was structured to resemble “normal” everyday life. On being woken up, patients were encouraged to bathe and dress. They were expected to do this themselves; it was considered “pointless” to try and force them to dress. This was a different approach to that adopted in most asylums where it was the nurses’ or attendants’ responsibility to dress the patients.¹⁴⁴ After breakfast, during which patients were encouraged to make conversation, they went to work in the occupation rooms. Here they were given classes in clay modelling, painting, weaving, bookbinding, knitting, leatherwork and basket weaving. Meyer regarded such handicrafts as a tool for igniting impulses of self-interest and the desire for satisfaction essential for efficient adaptation.¹⁴⁵ In the carpentry workshops, male patients made wooden trays, tables and bookshelves, while in the needlework room, female patients made

¹³⁹ Ibid. [italics in the original]

¹⁴⁰ Ibid., 90-2.

¹⁴¹ S. D. Lamb, *Pathologist of the Mind: Adolf Meyer and the Origins of American Psychiatry* (Baltimore: Johns Hopkins University Press, 2014), 174.

¹⁴² Ibid., 173.

¹⁴³ Meyer, “Philosophy of Occupational Therapy,” 88.

¹⁴⁴ Lamb, *Pathologist of the Mind*, 169.

¹⁴⁵ Ibid., 170.

slippers, shawls and tablecloths. Patients were encouraged to send their achievements home as gifts for their families and friends.¹⁴⁶ Lunch was followed by rest or quiet activities on the wards. These might include reading, card-playing, letter-writing or domestic tasks, such as clearing away meal trays, sweeping, bedmaking or polishing brass fixtures. The latter were considered therapeutic activities; the smooth-running of the hospital did not depend on patients' carrying out such tasks, as was the case in most American public hospitals. Meyer maintained that help around the wards, provided it was voluntary and pleasant and gave a sense of "helpful enjoyment", acted as an "instrument of biological adaptation".¹⁴⁷ This contrasted with the obligatory, often exploitative, labour of patients in the large public institutions, but was nonetheless focused on cultivating productivity and usefulness.

4.3.7 "More Active Therapy" (MAT) – the German Model

"More Active Therapy", unlike the brand of OT advocated by Meyer, was all based on the work that needed to be done to run the institution. In principle, this should have been more attractive to the French who were in desperate need of the material contribution made by patient work. In practice, however, the method required intense supervision by well-trained staff and high staff-to-patient ratios. When Simon took up the position of medical director of the newly-built Warstein Asylum, he discovered that the landscaping of the grounds had not been completed. With staff in short supply, Simon directed his patients to complete the work.¹⁴⁸ Initially he only selected those patients who were considered fit enough to work, but soon involved those who were agitated or in bed.¹⁴⁹ He observed that as more patients were involved, a general improvement in behaviour took place.¹⁵⁰ Patients became much calmer and more orderly, reducing the need for sedative drugs and isolation cells.¹⁵¹ Within nine years, Simon was able to occupy c.90% of his patients. The whole atmosphere of the institution changed into one of purposeful activity, and patients took a renewed interest in

¹⁴⁶ Ibid.

¹⁴⁷ Ibid., 180.

¹⁴⁸ Frederic Wertham, "Progress in Psychiatry II: The Active Therapy of Dr Simon", *Archives of Neurology and Psychiatry* 24,1(1930):151.

¹⁴⁹ Ankele, "The Patient's View of Work Therapy," 242.

¹⁵⁰ Wertham, "Progress", 151.

¹⁵¹ Ankele, "The Patient's View of Work Therapy," 242.

their surroundings.¹⁵² Simon realised that regular, serious activity was part of normal, everyday life and that scheduling some sort of work (however limited) into the daily routine, made the adjustment to institutional life easier for newly admitted patients.¹⁵³

On becoming medical director of the Gutersloh Asylum in Westphalia in 1919, Simon instituted a programme of occupation therapy known as “More Active Therapy” (*aktivere Krankenbehandlung*), publishing an account of his experiences in 1927 in a German psychiatric journal and in book-form in 1929.¹⁵⁴ Simon believed that every patient, even those at the acute stage of their illness, should be set to work on admission to hospital.¹⁵⁵ Patients should feel that the work assigned to them had a purpose, since this was essential to maintaining their engagement and interest in the work. Simon maintained that “the work allocated to a patient should be real and serious” and the patient should be paid for it, no matter how small the amount.¹⁵⁶ Simon did not believe in allowing patients to spend time creating works of art.¹⁵⁷ All the tasks were focused on work to maintain the institution, such as work in the laundry, kitchen, grounds, poultry house or offices. Simon insisted that “Whatever task can be done by someone who is sick is not be done by someone who is healthy.”¹⁵⁸ He also insisted that the economic value of the work was not its main goal, but that the focus should be on the benefit to the patient. Simon believed that the purpose of treatment was to “re-introduce a healthy logic into the life and mental world of the patient and a first principle of a healthy logic is, that what one does must have a sense and purpose.”¹⁵⁹ Work was balanced by social and recreational activities. Simon believed it was necessary to schedule some form of “activity” every day including Sundays.¹⁶⁰

Simon acknowledged that it required considerable education to habituate patients to work. The physician had to assess the mental state of the patient when allocating work and

¹⁵² Wertham, “Progress,” 151.

¹⁵³ Ibid., 152.

¹⁵⁴ Hermann Simon, “Aktivere Krankenbehandlung in der Irrenanstalt,” *Allgemeine Zeitschrift für Psychiatrie* 87(1927): 97-145.

¹⁵⁵ Ankele, “The Patient's View of Work Therapy,” 242.

¹⁵⁶ Wertham, “Progress,” 153.

¹⁵⁷ Ibid., 152.

¹⁵⁸ Hermann Simon, “Active Therapy in the Lunatic Facility (1929),” in *From Madness to Mental Health: Psychiatric Disorder and Its Treatment in Western Civilisation*, ed. Greg Eghigian (New Brunswick: Rutgers University Press, 2010), 273.

¹⁵⁹ Ibid.

¹⁶⁰ Wertham, “Progress,” 153.

deciding on the training method. Simon divided the work into five stages of increasing difficulty, which he compared to the grades of a school.¹⁶¹ New patients were initially assigned simple tasks – such as helping to carry a basket or dusting furniture – and as their performance improved, they were given ever more demanding assignments.¹⁶² The final stage, representing the normal work capacity of a healthy individual, might involve work outside the hospital, thereby strengthening a patient's sense of responsibility and independence.¹⁶³ Whilst a patient should not be allowed to become overtired, it was important to "push a patient to the upper limits of their abilities" in order that they made progress. Striking this balance was a challenge for the physician.¹⁶⁴ The aim was to educate patients to take responsibility for their actions and to play a useful role in the community. This ethos, as Monica Ankele emphasises, resonated with that of other German welfare institutions, such as alms-houses, youth centres and prisons, during the Weimar period, where work played a central role.¹⁶⁵

4.3.8 From Patient Work to AOT in England

It was the American concept of OT, rather than the German MAT, that first influenced the development of new approaches to patient occupation in England. This was because it had been introduced to Britain in the early 1920s, whereas MAT only began to attract attention in Britain in the late 1920s and early 1930s. It was the Scottish psychiatrist, Dr (later "Sir") David Henderson, who had worked for Meyer in New York from 1908 to 1910, and at the Henry Phipps Clinic in Baltimore from 1912 to 1915, who is credited with introducing AOT to Britain. Henderson learned Meyer's methods of identifying patients' reaction types, analysing the significance of their social backgrounds and applying the techniques of AOT.¹⁶⁶ On becoming Physician-Superintendent of the Glasgow Royal Lunatic Asylum at Gartnavel in 1921, Henderson cultivated Meyer's psychobiological approach, introducing Meyer's case

¹⁶¹ Ibid., 152.

¹⁶² Simon, "Active Therapy in the Lunatic Facility (1929)," 273-5.

¹⁶³ Ibid., 275.

¹⁶⁴ Ibid., 274.

¹⁶⁵ Ankele, "The Patient's View of Work Therapy," 242.

¹⁶⁶ Hazel Morrison, "Henderson and Meyer in Correspondence: A Transatlantic History of Dynamic Psychiatry, 1908-1929," *History of Psychiatry* 28, no. 1 (2016): 75-6.

note-taking procedures and his system of creating patient records.¹⁶⁷ Henderson also introduced occupational therapy to Gartnavel, emphasising its importance in his Annual Report of 1922, in which he claimed that “attempts should be made to cultivate good habits in both mind and body, to stimulate interests, and attempt in every way to reconstruct the personality”.¹⁶⁸

Henderson’s advocacy of occupational therapy was complemented by articles on AOT appearing in the British *Journal of Mental Science* from 1922 onwards. These were mainly reviews of items appearing in the American journal, the *Archives of Occupational Therapy*, and included the review of Meyer’s paper, “The Philosophy of Occupational Therapy” in 1922.¹⁶⁹ Papers read at Henderson’s conference on AOT, which he organised in Glasgow in 1924, were published in the *Journal of Mental Science* in 1925. At the conference, Henderson expressed the belief that through AOT “many recoveries are hastened, many improvements are effected, good habits are substituted for bad ones, physical and mental deterioration are retarded, and life is made more endurable for the great bulk of our permanent population”.¹⁷⁰

Henderson re-affirmed his commitment to Meyer’s psychobiological approach in his *Textbook of Psychiatry* (1927), written with colleague R.D. Gillespie and dedicated to Meyer. The textbook became the standard textbook for postgraduate students of psychiatry, running to several editions until finally being withdrawn in the late 1970s.¹⁷¹ In a chapter devoted to OT, Henderson declared that every mental hospital should have an OT department, “varied to suit the individual needs of the institution, private or parochial, rural or urban”.¹⁷² He believed that guiding patients into “satisfactory work channels” could accomplish more than “all the drugs in the pharmacopoeia”.¹⁷³ Noting that in the past, patient work frequently constituted “mere drudgery” that must have “antagonised” rather

¹⁶⁷ Ibid., 82.

¹⁶⁸ Cited in Paterson, *Opportunities Not Prescriptions*, 30.

¹⁶⁹ Marjorie Franklin, Review of “The Philosophy of Occupational Therapy” by Adolf Meyer, *Journal of Mental Science* Oct (1922):422.

¹⁷⁰ Cited in: Paterson, *Opportunities Not Prescriptions*, 31.

¹⁷¹ Gelder, “Adolf Meyer and His Influence,” 431.

¹⁷² D.K. Henderson and R.D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners*, 5th ed. (London: Oxford University Press, 1940), 600.

¹⁷³ Ibid.

than helped many patients, he maintained that properly organised OT could inspire in patients a “spirit of hopefulness and of happiness”.¹⁷⁴

The BoC advocated OT as a means of engaging mentally ill patients who refused, or were unable, to perform hospital maintenance work. They admitted that employment had been restricted to “those patients whose readiness to work was spontaneous or needed only the urge of some small reward”.¹⁷⁵ As Henderson highlighted, many patients who had been considered unemployable could be occupied by “staff trained in teaching handicrafts” if sufficient care was taken to select an activity that appealed to the patient and was appropriate for their mental condition.¹⁷⁶ The Board noted in 1931 that where a “skilled occupation officer” had been appointed, as at Barming Heath, this had resulted in the “employment of types of recent and progressing cases who a few years ago would have been regarded as incapable of benefiting by such treatment”.¹⁷⁷

The German method of occupational therapy developed by Hermann Simon (MAT) only became widely known in British psychiatric circles following study visits to Germany and Holland convened by the Royal Medico-Psychological Association (RMPA)¹⁷⁸ between 1929 and 1933. MAT was not discussed in the *JMS* before 1929. The Board used the research from these study visits, together with existing knowledge of AOT, to produce a *Memorandum on Occupation Therapy* in 1933. The 27-page booklet, published to galvanise medical superintendents to introduce OT into their hospitals, constituted “a significant early policy document in the history of occupation”, according to John Hall.¹⁷⁹

The BoC booklet set out the different ways that OT could be conducted in English mental hospitals, outlining the purpose of OT, the methods used in the US, Germany and Holland and how they might be adapted for use in English mental hospitals. It also advised on staff training and the financial implications of introducing OT.¹⁸⁰ The BoC defined OT as “the treatment, under medical direction, of physical or mental disorders by the application of occupation and recreation with the object of promoting recovery, of creating new habits,

¹⁷⁴ Ibid., 593, 600.

¹⁷⁵ Fifteenth Annual Report of the BoC, 1928.

¹⁷⁶ Ibid.

¹⁷⁷ Eighteenth Annual Report of the BoC, 1931.

¹⁷⁸ The MPA became a “Royal” association in 1926.

¹⁷⁹ Hall, “From Work and Occupation to Occupational Therapy,” 320.

¹⁸⁰ Board of Control, *Memorandum on Occupation Therapy for Mental Patients* (London, HMSO: 1933).

and of preventing deterioration”.¹⁸¹ The *Memorandum* downplayed the economic value of occupation to the hospital, stating that “the object of occupation is primarily therapeutic” and should not be viewed as a means of “providing commodities for use in the hospital at a low cost”.¹⁸² The BoC were keen to make a sharp distinction between OT and mere occupation; for occupation to be therapeutic it had to be prescribed by a doctor and delivered by specialist staff trained in this “branch of medical therapy”.¹⁸³ This emphasised both the medicalisation and professionalisation of OT.

The *Memorandum* maintained that OT could comprise either employment in the existing hospital departments (such as the kitchen, laundry, farms or gardens, or workshops), or handicrafts and “other less strictly utilitarian activities”, for example sewing, embroidery, lace-making, knitting, raffia-work, quilting, netting, weaving, or rug-making (for women) and woodwork, metal-work, painting, French polishing, weaving, or basketry (for men).¹⁸⁴ The tasks in the first type of employment were no different from those performed pre-OT, but the difference lay in the approach, according to the *Memorandum*. The same argument applied to the craft activities. Certain private or registered hospitals, where resources were more plentiful, may have offered arts and crafts-based activities to patients as a distraction, but the medically prescribed *therapeutic* use of handicrafts was new and not an occupation that had been undertaken in public mental hospitals. The new approach involved identifying the appropriate type and level of activity for the patient’s mental condition.¹⁸⁵

The therapeutic benefits of OT for the patient were highlighted as the “favourable influence” on a patient’s mental attitude, the promotion of good habits and socialisation, an improvement to physical health, and the “drawing out” of patients from a self-imposed “pseudo-privacy”.¹⁸⁶ A rehabilitative advantage was also highlighted; OT made the re-adjustment to the world of work “a more agreeable task” and reduced the anxiety of returning to the “responsibilities of normal life” (and by inference, of earning a living).¹⁸⁷

¹⁸¹ Ibid., 3.

¹⁸² Ibid., 7.

¹⁸³ Ibid., 15.

¹⁸⁴ Ibid., 4-5.

¹⁸⁵ Ibid., 19-24.

¹⁸⁶ Ibid., 7.

¹⁸⁷ Ibid., 4.

The workshops and hospital departments were seen as providing “the finishing treatment” of convalescent patients who were soon to resume their lives in the outside world.¹⁸⁸

The Board declared that doctors had found habit-training through occupation was more “instrumental in preventing much of the deterioration of mind and habit occurring in dementia” than any other single factor.¹⁸⁹ They also highlighted the benefit of occupation for restless, disturbed and violent patients for whom occupation might not have been considered suitable in the past. It was noted that unruly behaviour “tend[ed] to disappear under treatment”.¹⁹⁰ Work in the hospital departments was deemed beneficial for “quieter and more tractable patients” who would not compromise the “efficiency of the service”.¹⁹¹ The Board acknowledged that work in the hospital departments was particularly suited to calm, incurable patients (who had always tended to be a hospital’s “best workers”), but it was felt that curable patients could also benefit from this work, including (on the male side) convalescent patients.¹⁹² Most importantly, the needs of the individual patients were to be “the determining factor”.¹⁹³ Also considered crucial was the support of the medical staff, without which “occupational treatment in its main purpose must fail”.¹⁹⁴ Medical superintendents needed to become familiar with OT and consider it an integral aspect to the medical treatment and nursing of patients.¹⁹⁵

4.3.9 Patient Work in France

The adoption of new methods of occupying patients were making progress in England, but not in France, where the efforts of psychiatrists keen to augment opportunities for therapeutic work and occupation in French institutions were largely overlooked. Georges Demay joined forces with Swiss psychiatrist Charles Ladame, medical director of the Bel-Air Asylum in Geneva from 1925 to 1939, to write a book on the subject in 1926.¹⁹⁶ Patient

¹⁸⁸ Ibid., 8.

¹⁸⁹ Ibid., 6.

¹⁹⁰ Ibid.

¹⁹¹ Ibid., 6.

¹⁹² Ibid., 7.

¹⁹³ Ibid.

¹⁹⁴ Ibid., 23.

¹⁹⁵ Ibid., 18.

¹⁹⁶ C. Ladame and G. Demay, *La Thérapeutique des Maladies Mentales par le Travail* (Paris: Masson et Cie, 1926).

work was used extensively in both the Bel-Air Asylum, which opened in 1900 and Demay's Clermont Asylum, a much older, originally private institution that became a public asylum in 1887. Demay, along with Parisian psychiatrists including Paul Courbon, Maurice Legrain, Jacques Vié and Paul Wahl, campaigned – unsuccessfully for the most part – for the provision of improved facilities for patient occupation in France throughout the interwar period.

In their 1926 work, *La thérapeutique des maladies mentales par le travail*, Ladame and Demay tried to advance contemporary thinking on patient work.¹⁹⁷ They highlighted that in the past, patient work had been indicated for convalescent and calm, chronic patients, but not for patients at the acute stage of their illness, nor for those suffering from severe mania or melancholia. They suggested that medical thinking on this matter had evolved and that work could be appropriate for acute patients, although not at the very beginning of their illness, when bed-rest was indicated. They considered, for example, that it was not considered necessary to wait until the agitation of delirious patients had completely disappeared. Work could fix their attention, channel their energy and facilitate a change in habits.¹⁹⁸ The benefit of work as a distraction was illustrated by the case of a patient suffering from delusions of persecution who remained perfectly calm when working in the fields for six days out of seven, but on Sundays his delirium returned, resulting in noisy monologues and gesticulations.¹⁹⁹ Work was beneficial for melancholic patients, either as a means of encouragement to engage with their surroundings, or as a refuge and a distraction. In both cases, however, patients needed to be carefully monitored. In Ladame and Demay's opinion, some dementia patients were also capable of work, including those suffering from dementia praecox. They noted that Morel found work helped to retard the deterioration of dementia praecox patients, while Bleuler claimed that work was one of the most effective means of treating schizophrenia.²⁰⁰

Patients at the acute phase of their illness needed to remain under medical surveillance, so workshops for these patients had to be situated within the interior of the patient quarters,

¹⁹⁷ Ibid.

¹⁹⁸ Ibid, 22.

¹⁹⁹ Ibid.

²⁰⁰ Ibid., 24.

which was unusual in French asylums.²⁰¹ An enquiry conducted by Ladame and Demay had revealed that only two out of the 25 French asylums surveyed had interior workshops.²⁰² Establishing interior workshops was recommended by the authors since they could provide work (such as basketry, mat-making, brush-making, book-binding, knitting or sewing) for a large group of patients who would otherwise be left unoccupied. They suggested the introduction of local industries, such as lace-making, glove-making or weaving, with which patients may have been familiar.²⁰³ Ladame and Demay cited the example of the Third Section of the Villejuif Asylum, where even the most “difficult” patients worked in small workshops in the interior of their quarters.²⁰⁴

The Villejuif Asylum’s Third Section for criminal and dangerous patients, established by Henri Colin in 1910, was one of the few French asylums where interior workshops existed, and could provide a model for other establishments.²⁰⁵ All Third Section patients were obliged to engage in work that was productive, since criminals were expected to contribute to the costs of their maintenance.²⁰⁶ Colin, who had outlined the work of the Third Section in the *AMP* in 1912-13, claimed that although doctors had not sent agitated or violent patients to the workshops in the past because they required continual surveillance, many of these patients were excellent workers.²⁰⁷ By situating the workshops (including shoe-repair, machine-knitting, tailoring, furniture repair and carpentry workshops) within the patient quarters, productive work could be achieved, supervised by nurses experienced in manual labour.²⁰⁸

The work regime of the Villejuif’s Third Section was presented to the Congress of French Alienists and Neurologists in Geneva in 1926 by Dr Calmels. His report, published in the *AMP* in 1927, endorsed the views of Ladame and Demay, emphasising that interior workshops would enable the employment, not only of the criminally insane, but of many hitherto

²⁰¹ Ibid.

²⁰² Ibid., 7.

²⁰³ Ibid.

²⁰⁴ Raynier and Beaudouin, *L’Aliéné*, 314.

²⁰⁵ Ladame and Demay, *La thérapeutique*, 34.

²⁰⁶ The disciplinary and therapeutic aims of work for patients in the Third Section are the subject of research by Fau-Vincenti, “Valeur Du Travail À La Troisième Section De L’hôpital De Villejuif” (accessed 15/04/2016).

²⁰⁷ Henri Colin, “Le Quartier de Sureté de Villejuif (Aliénés criminels, vicieux, difficiles, habitués des asiles),” *AMP* novembre (1912): 370-391, décembre(1912): 540-548; janvier (1913): 36-65, février (1913): 170-177.

²⁰⁸ Colin, “Le Quartier de Sureté,” *AMP* février (1913): 171-2.

unoccupied patients, such as patients suffering from chronic delirium, dementia praecox or GPI. These patients were forced to remain in their quarters, with nothing to do, despite being capable of simple work.²⁰⁹ The atmosphere of boredom and sadness, so often evident in quarters where patients were idle, could be replaced by one of activity and purpose. Furthermore, claimed Calmels, chronic patients could fulfil a useful, social role.²¹⁰ Demay recognised that overcrowding (a problem for so many French asylums during this period) could be an impediment to the establishment of interior workshops. The latter could not be accommodated in asylums where 50-60 patients were crammed into a small area that served both as day-room and refectory.²¹¹ In any case, in most French asylums, there were not enough experienced nurses to supervise patient activities, particularly those involving more challenging patients.²¹²

Ladame, Demay and Calmels were clearly advocating work for a wider cohort of patients, with a more diverse range of conditions, before the principles of MAT became widely known. The average percentage of patients given work in French asylums was not given in Ladame and Demay's 1926 report, but elsewhere a figure of 50-55% was indicated.²¹³ Demay maintained in 1929 that the figures regarding patient workers in Swiss and Dutch asylums were "unknown in France".²¹⁴ In the Swiss asylum at Wil, under Dr. Schiller, 83% of male and 75% of female patients were working, while at the Santpoort asylum in Holland (where MAT had been introduced in 1926), 90% of patients worked.²¹⁵ Demay suggested that French doctors were being "too timid" in their allocation of work to patients. The peaceful, chronic patients and the inoffensive, intellectually impaired, together with the convalescents, were sent to work, but most of the other patients were consigned to overcrowded quarters and remained unoccupied all day, apart from a small number cleaning the wards. Demay said that it was time to get the agitated, the impulsive, the perverse, the violent and the escapees to work, by making the appropriate arrangements,

²⁰⁹ M. Calmels, "Le Travail par petits ateliers à la troisième section de l'Asile de Villejuif," *AMP* no. 1 (1927): 283.

²¹⁰ *Ibid.*, 283.

²¹¹ G. Demay, "Les conditions de la thérapeutique par le travail dans les asiles," *L'Hygiène Mentale* no. 2 (1929): 35.

²¹² *Ibid.*

²¹³ Dr Lautier, "Les Exagérations de la Thérapie par le Travail," *L'Hygiène Mentale* no. 2 (1929): 191.

²¹⁴ Demay, "Les conditions," 33.

²¹⁵ *Ibid.*

such as introducing interior workshops and ensuring that adequate security measures were in place.²¹⁶

4.3.10 The Reception of MAT by French Psychiatrists

Following Ladame and Demay's efforts to try and improve the use of patient work in France, French psychiatrists became aware of MAT. The methods of "more active therapy" (MAT) were first explained in detail to an audience of French psychiatrists in 1928. Parisian psychiatrist Paul Courbon was amongst a group of delegates attending the thirty-second Congress of French-speaking alienists and neurologists (which took place at Anvers in July 1928), invited to visit a number of Dutch asylums after the meeting. The visit included the asylum at Santpoort, where Hermann Simon's methods had been introduced two years earlier. Courbon shared his observations in the *AMP* in November 1928.²¹⁷ Simon published a series of articles in the German psychiatric journal, the *Allgemeine Zeitschrift*, in 1927 and his book, *Aktivere Krankenbehandlung in der Irrenanstalt*, appeared in 1929.²¹⁸ Neither the articles nor the book were translated into French, but they attracted the attention of French psychiatrists, Paul Schiff and G. Halberstadt in 1929, and Jacques Vié in 1934.²¹⁹ Patient work in Dutch asylums, including Santpoort, was analysed by A. Porot in the journal *L'Hygiène mentale* in 1929.²²⁰ These articles reinforced the notion that more French patients could and should be occupied.

For the practitioners of MAT, there were very few conditions that would prevent patients from working. When Paul Courbon visited Santpoort, he noted that out of 1,420 patients, 1,273 were working. Out of the 147 unoccupied patients, 112 were too physically weak to work, leaving just 35 whose mental conditions prevented them from working. Bed-rest quarters were greatly reduced and were reserved for "organic" cases or the very agitated who were being treated with the sedative, somnifene.²²¹ Porot observed that hydrotherapy

²¹⁶ Ibid., 34.

²¹⁷ P. Courbon, "Un voyage d'étude dans les asiles de Hollande," *AMP* no. 2 (1928): 289-306 and 385-405.

²¹⁸ Hermann Simon, *Aktivere Krankenbehandlung in der Irrenanstalt* (Berlin: de Gruyter, 1929).

²¹⁹ P. Schiff, "Le mouvement d'hygiène mentale en Allemagne," *L'Hygiène mentale* no. 8 (1929): 232-233; G. Halberstadt, "A propos de l'Ergothérapie," *AMP* mars (1929): 193-198; J. Vié, "Le traitement des malades mentaux par le travail: les idées et les réalisations de H. Simon," *L'Aliéniste français* (1934): 589-598.

²²⁰ A. Porot, "L'Assistance par le travail dans les Asiles Hollandais," *L'Hygiène mentale* no. 2 (1929): 41-54.

²²¹ Paul Courbon, "Voyage d'études dans les asiles de Hollande," *AMP* no. 2 (1928): 395.

equipment had been abandoned because it was no longer required to soothe agitated patients, who were now occupied. There were no patients huddled on benches, nor any crying out or shouting. Night-time agitation had practically disappeared, and isolation cells were no longer in use.²²² All the available workforce was being used, with 85-90% of patients systematically working – either in bed, in their quarters, in the workshops, or in the grounds.²²³

Hermann Simon, the creator of MAT, believed that, apart from conditions derived directly from organic causes, no symptoms, even the most serious, were incompatible with work, provided it was carefully prescribed and supervised.²²⁴ Sharing his views directly with a French audience in 1933, he said that work was one of the best means of combatting agitation, impulsivity and a tendency to violence. Whilst work could not cure organic lesions, it could nonetheless strengthen a patient's physical and mental faculties.²²⁵ Figures presented in a report on patient work to the Superior Council for Public Assistance in 1934 revealed that at Simon's asylum in Gutersloh, and at Santpoort where his methods were closely followed, 96% of patients were employed.²²⁶

What so impressed Paul Courbon when he visited Santpoort and other Dutch asylums was the silence. Patients worked from 0900 to 1200 and from 1400 to 1700 and were not allowed to speak whilst working.²²⁷ The moment patients became agitated they were removed from the work room for half an hour to rest and then brought back again. If they re-offended, they were removed for a longer period; if this proved insufficient, the patients were given the sedative somnifene. Courbon found the results of this method were "extraordinary", while for Porot they were "revolutionary".²²⁸ Courbon described the method of treatment as "*ergothérapie*" or occupational therapy, which was not a term in regular use in France prior to this period. It consisted, he explained, of re-educating the automatic responses of patients and helping them to readapt to social life.²²⁹ The

²²² Porot, "L'Assistance par le travail," 45-7.

²²³ Ibid., 52.

²²⁴ Hermann Simon, "La Psychothérapie à L'Asile," *L'Hygiène Mentale* no. 1 (1933): 21.

²²⁵ Ibid., 20.

²²⁶ D-M. Legrain and G. Demay, "Le travail des aliénés convalescents," *L'Aliénist Français* no. 6 (1936): 283.

²²⁷ Courbon, "Voyage d'études," 396.

²²⁸ Ibid., 397; Porot, "L'Assistance par le travail," 52.

²²⁹ Courbon, "Voyage d'études," 397.

application of MAT totally transformed the atmosphere of asylums; everywhere there was silence, concentration and an impressive discipline.²³⁰ Porot believed that the methods he had witnessed at Santpoort and other Dutch asylums was not simply a way of filling the time and occupying idle hands, but a means of active therapy that countered agitation and other symptoms. It was, as Courbon claimed, “*une véritable rééducation*”.²³¹

As Simon maintained, “all psychotherapy is above all an education ... that is to say, it acts on the will of patients with the goal of improving their ability to adapt to their environment”.²³² Patients lacked judgement and understanding, so doctor and nurses assumed the role of “spiritual guide”, rather like that of a mother using her authority to guide a child in the appropriate direction.²³³ Simon maintained that authority was the basis of all successful psychotherapy; not based on force or strict rules, but on the “spiritual superiority” of the therapist. This, he insisted, had been recognised by the great psychiatrists of the past such as Pinel, Reil, Griesinger and Conolly.²³⁴ It was important not to treat patients as “mad” but as sane individuals capable of normal behaviour. Patients were to be respectful of others, and to remain calm and orderly. They were not to use foul language or shout, to shred their clothes or march up and down. These objectives were best achieved by encouraging patients in an occupation, teaching them good working habits, and developing their sense of responsibility.²³⁵ Patients who behaved well and showed a willingness to work were rewarded with certain privileges; such as greater freedom or attendance at special events (parties, concerts, theatrical performances). In contrast, those who engaged in antisocial behaviour were deprived of certain benefits.²³⁶ As a patient improved, s/he would be given work involving greater responsibility. It was important to keep raising the patient’s expectations of him/herself to maintain progress.²³⁷ Outside working hours, the patient’s mind should still be kept occupied with lectures, conversation and physical exercise.²³⁸

²³⁰ Porot, “L’Assistance par le travail,” 52.

²³¹ Ibid.

²³² Simon, “La psychothérapie,” 21.

²³³ Ibid., 22.

²³⁴ Ibid., 22.

²³⁵ Ibid., 23-5.

²³⁶ Ibid., 26.

²³⁷ Ibid., 26.

²³⁸ Ibid., 27.

Patients should not be allowed to discuss or dwell upon their troubles; work and activities should distract them.²³⁹

Simon's methods were explained in much greater detail in his book (1929), which was reported on by Jacques Vié in 1934. In terms of the practical organisation of work, Vié noted that Simon rated work in the open air as one of the best means of both physical and mental treatment, for which it was necessary to have a significant area of land. Simon recommended a wide variety of indoor occupations that could be conducted either in the workshops or within patient quarters.²⁴⁰ All the tasks related to the running of the institution and could be replicated in any asylum. It was essential that the work was well-organised and directed by the psychiatrist, who could ensure that it was regarded by all concerned as a means of therapy.²⁴¹ The psychiatrist was the only person qualified to decide on the type of work to be allocated to each patient. At Gutersloh, the psychiatrists and senior nurses began each day dividing the work between patients and work teams, based on their knowledge of the patients, their conditions and their aptitudes. Each work team had a particular therapeutic goal which could be achieved by a certain type of work.²⁴²

The choice of work for each patient, and their assignation to a work team, were among the most "delicate" tasks of the psychiatrist.²⁴³ Vié noted that Simon referred to the necessity of medical control of the work regime several times in his book. This was essential for the work to be oriented towards a therapeutic goal, rather than an economic one.²⁴⁴ The CMO was in a position to ensure that all staff shared this ethos. This was an important point since Simon acknowledged that the interests of exploitation and therapy were not always in harmony.²⁴⁵ Those responsible for asylum management must be united in serving the best interests of patients, since any discord between the medical and economic teams could lead to severe difficulties and compromise patient well-being. Simon was clear that the success of MAT depended on the medical direction of the asylum.²⁴⁶

²³⁹ Ibid., 27.

²⁴⁰ J. Vié, "Le traitement des malades mentaux par le travail," 595.

²⁴¹ Ibid., 596.

²⁴² Ibid., 596.

²⁴³ Ibid., 597.

²⁴⁴ Ibid., 597.

²⁴⁵ Ibid., 598.

²⁴⁶ Ibid., 598.

Hermann Simon's methods of MAT generated considerable interest amongst a specific cohort of French psychiatrists between 1928 and 1939.²⁴⁷ These psychiatrists, mainly although not exclusively from Paris, recognised the benefits of a re-educative approach to treating mental disorder, based on Simon's psychological methods incorporating his type of OT, MAT. This put them at odds with their colleagues who adhered to a neurological interpretation of mental disorder and favoured biological methods of treatment. The French psychiatrists in favour of MAT were pessimistic about their ability to introduce MAT into French asylums. They acknowledged the various impediments inherent in the French system that made the introduction of MAT, or a similar methodology, something to which asylum CMO's might aspire, rather than adopt wholesale, as Dr Van der Scheer had done at Santpoort. Overcrowding; lack of funds; management issues; and staff quality, training and numbers constituted barriers to the replication of Simon's methods in French asylums. As A. Walk commented in the English *JMS*, the "fully-developed Simon system [MAT] ... involves a transformation of the hospital régime" that could only be compared with the asylum reforms introduced in the early nineteenth century.²⁴⁸ Under Simon's system, Walk maintained, "the entire institution becomes one vast occupational centre" and that the "therapeutic application of work, rest and recreation" was the "foremost concern" of all the asylum staff working in collaboration.²⁴⁹ The system clearly involved a fundamental change not only in the way the asylum was run, but in the attitudes and skills of staff, that represented a daunting undertaking even for an institution without the problems suffered by French asylums. The main barrier to the introduction of MAT, however, was the organicist stance of many French psychiatrists, whose outlook remained shaped by psychiatry's close links with neurology.

4.3.11 The Difference between Work, AOT and MAT

The neurological orientation of French psychiatrists led them to prefer biological methods of treatment for acute cases of mental disorder, rather than psychological methods, such as

²⁴⁷ Although according to Hervé Guillemain, Simon's methods were not widely known in France until after World War II.

²⁴⁸ A. Walk, "Occupation Therapy and 'Active Therapy'," *Journal of Mental Science* Oct (1933): 759.

²⁴⁹ Ibid.

OT. Patient work, on the other hand, was considered beneficial for chronic and convalescent patients. The traditional form of patient work, as practised before World War I, and Hermann Simon's More Active Therapy (MAT), both consisted of useful work that contributed to the smooth-running of the institution, which raises the question of how MAT differed from the therapeutic work already undertaken by patients in French asylums. MAT involved a subtle and sophisticated assessment of a patient's mental state, aptitudes and particular needs before the assignation of appropriate work, followed by a process of training the patient to perform the task and supervising its execution. Patients were guided through five different levels of difficulty, with the earliest, easiest stage (such as litter-picking) reserved for newly admitted, acute patients, while work at the final stage, designed to be as similar as possible to normal work outside the hospital, was prescribed to patients nearly ready for discharge. The idea of graded activities, prescribed to suit the level and abilities of the patient, had originated in the treatment of tuberculosis. The English physician Marcus Paterson, superintendent of the Brompton Hospital Sanatorium, developed a programme of graduated labour, comprising six levels of work designed to build up a patient's stamina, in the early 1900s.²⁵⁰ Paterson noticed that the programme resulted in psychological as well as physical improvement.²⁵¹

There was nothing intrinsically different about the type of work outlined in Simon's programme and the regular work performed by hospital patients. The difference lay in the way it was prescribed; the graded levels of difficulty; the training and supervision of patients; and the fact that almost all patients, including the acutely ill, were given some sort of productive work. Simon believed that even patients at the acute stage of their illness should be occupied; work was not just for the chronic and convalescent patients. But his methods required significant enthusiasm and support from the CMO; the existence of medical officers to assist with supervision; sufficient numbers of well-trained; competent nurses; and enough flexibility within the system to allow for a re-organisation of the hospital regime. In most French mental hospitals during the interwar period, the above requirements were lacking. In particular, support for OT was less likely to be forthcoming

²⁵⁰ Cynthia Creighton, "Graded Activity: Legacy of the Sanatorium," *American Journal of Occupational Therapy* 47, no. 8 (1993): 746.

²⁵¹ Ibid.

from French CMOs than their English counterparts because of the inclination of French psychiatrists towards biological, rather than psychological, modes of treatment.

In England, where a psychobiological rather than a neurological approach prevailed, AOT was adopted as a means of engaging mentally ill patients who refused, or were unable, to perform hospital maintenance work. Henderson highlighted the fact that under the old system, many patients remained unemployed, either because of “inefficiency, helplessness, or poor general state of health”, while the new system was designed to appeal to those who had never been employed and to “stimulate anew” those who had failed.²⁵² The Board also admitted that employment had been restricted to “those patients whose readiness to work was spontaneous or needed only the urge of some small reward”.²⁵³ Many patients who had been considered unemployable could be occupied by “staff trained in teaching handicrafts” if sufficient care was taken to select an activity that appealed to the patient and was appropriate for their mental condition.²⁵⁴ Henderson observed that the allocation of work required “endless patience and good organisation”.²⁵⁵ The Board noted in 1931 that where a “skilled occupation officer” had been appointed, as at Barming Heath, this had resulted in the “employment of types of recent and progressing cases who a few years ago would have been regarded as incapable of benefiting by such treatment”.²⁵⁶

Although English mental hospitals had not been “transformed” into the hives of productive activity that described the continental institutions where MAT had been fully introduced, the employment of an occupational therapist clearly made a difference to the lives of patients who had previously been idle. The introduction of AOT, albeit a “therapeutic measure applied to a certain number of individual patients” that, unlike MAT, left “untouched the general character of the hospital”, was highly beneficial to the patients involved, according to psychiatrist A. Walk.²⁵⁷ While work in the service departments and institutional farms continued to be prescribed for chronic and convalescent patients, the financial benefits of this work were downplayed. The introduction of OT changed the way acute patients, and those with severe symptoms, were treated. In France, on the other

²⁵² Henderson and Gillespie, *A Text-Book of Psychiatry for Students and Practitioners*, 594.

²⁵³ Fifteenth Annual Report of the BoC, 1928, 4-5.

²⁵⁴ Ibid.

²⁵⁵ Henderson and Gillespie, *A Text-Book of Psychiatry for Students and Practitioners*, 594.

²⁵⁶ Eighteenth Annual Report of the BoC, 1931, 10.

²⁵⁷ Walk, “Occupation Therapy and ‘Active’ Therapy,” 758.

hand, neither MAT nor AOT were adopted in French asylums. Acute patients were treated biologically and were not prescribed occupation, although at the HRH they were encouraged to keep busy. In most French asylums, patient work continued as it had done before World War I. The contribution to institutional running costs made by patient work continued to be a priority.

4.3.12 Transnational Considerations

The few French psychiatrists who campaigned for a new approach to patient work tended to support the German model of MAT, while Édouard Toulouse was inspired by the American model of Mental Hygiene (although his support for AOT is less evident).²⁵⁸ French support for the German model might initially seem surprising since the French had been traditionally hostile to everything German since the defeat of France by Germany in the Franco-Prussian War of 1870-71.²⁵⁹ This defeat intensified the French sense of inferiority with regard to Germany, initiated by the loss of French scientific and medical supremacy to Germany earlier in the century.²⁶⁰ The university chair established in Germany in 1863 demonstrated German psychiatry's scholarly and scientific legitimacy, while the ground-breaking work of Emil Kraepelin, whose influential *Textbook of Psychiatry* was published in eight editions between 1883 and 1915, sealed their victory over French psychiatry.²⁶¹ Postgraduate students flocked to Kraepelin's clinic in Munich, rather than Paris, to study psychiatry under the "new master".²⁶² French psychiatrists were anxious to re-establish their reputation by emulating, or surpassing, German achievements. Recommendation of MAT may have been part of a conscious or unconscious attempt to ensure that French asylums kept pace with developments in Germany.

New concepts of patient work and occupation were associated with a psychological or psychobiological approach, rather than an organicist approach to psychiatry. The French

²⁵⁸ Postel and Quélet, *Nouvelle Histoire De La Psychiatrie*, 351.

²⁵⁹ *Ibid.*, 350.

²⁶⁰ George Weisz, "Reform and Conflict in French Medical Education, 1870-1914," in *The Organisation of Science and Technology in France 1808-1914*, ed. Robert Fox and George Weisz (Cambridge: Cambridge University Press, 1980), 64-5.

²⁶¹ Goldstein, *Console and Classify*, 350; Lerner, *Hysterical Men*, 16.

²⁶² *Ibid.*

psychopathological and psychoanalytical groups highlighted in Aubrey Lewis's 1937 report "remained strictly Parisian" (i.e. Paris-based) during the interwar period and had little impact on asylums outside the capital.²⁶³ It is therefore plausible to assume that new ideas regarding patient occupation would not find favour outside Paris. Dr Christy of the ADLS was quite clear that his treatment priorities for curable patients were actively biological, while work remained a useful means of occupying chronic patients.²⁶⁴ Within Paris, a new approach to occupation had been adopted by the Third Section of the Villejuif for difficult and dangerous patients, under the auspices of Dr Henri Colin, a close associate of Toulouse.²⁶⁵ At the HRH, there is frustratingly little evidence of new approaches to occupation being adopted, although as indicated in the following sections, patient work and occupation appeared to be optional and were not essential to the maintenance of the hospital. The Asile Clinique remained influenced by neurologically-oriented practitioners (the more psychologically-oriented, younger members of staff did not have a significant impact until after World War II), which is reflected by the small numbers of patient workers within the treatment sections.

In England, those who held purely organicist views of mental disorder had been forced to retreat since shell-shock had been shown to have a psychological basis (by the Maghull psychiatrists). The leaders of British psychiatry who emerged during the interwar period, including Edward Mapother and Aubrey Lewis of the Maudsley, R.D. Gillespie of Guy's Hospital and D.K. Henderson of the Royal Glasgow Infirmary, all embraced the psychobiological approach of the American psychiatrist, Adolf Meyer.²⁶⁶ The latter believed that "psyche" and "soma" should be considered as different dimensions of the same entity. For Meyer, mental illness was not a structural defect of the mind or body, but a lowering of an individual's capacity to function or to adapt to his social situation. Differences between normality and abnormality, between psychosis and neurosis were not absolute, but shades of grey.²⁶⁷ Meyer's "theoretical conception of the unity of mental disorder" underpinned the Maudsley's pioneering work in outpatient treatment and voluntary admission. Mental

²⁶³ Coffin, "'Misery and Revolution'," 231.

²⁶⁴ Rapport du Médecin en Chef, l'Asile de la Sarthe (ADLS), 1935, 11.

²⁶⁵ Dr Calmels, "La thérapeutique des malades mentales par le travail," *Annales Médico-psychologique* no. 1 (1927):277.

²⁶⁶ Hayward, *The Transformation of the Psyche*, 69.

²⁶⁷ Edgar Jones, "Aubrey Lewis, Edward Mapother and the Maudsley," *Medical History Supplement* (2003): 14.

health and mental illness were a reflection of an individual's life situation and merely comprised points on a spectrum of behaviour.²⁶⁸ Meyer's methods of treatment of the functional psychoses, including guidance, re-education, occupational therapy and home visits by social workers were adopted at the Maudsley.²⁶⁹

So, the French psychiatrist Toulouse, and his few close Parisian associates, appeared to be influenced by the American model of occupational therapy, as a result of Toulouse's contact with American psychiatry through the Mental Hygiene Movement. However, Toulouse himself was a divisive figure who did not "win over" his more neurologically oriented colleagues. They regarded his establishment of the SLPM as a threat to their *modus operandi* which revolved around the "closed" asylum. Those French psychiatrists (other than Toulouse, who was influenced by the US) who sought a less rigidly organicist interpretation of psychiatry looked to their German rivals for a model of occupational therapy to emulate, but their recommendations of MAT did not resonate with the predominantly organicist alienists and neuropsychiatrists. In Britain, personal contact between Adolf Meyer and a number of British psychiatrists prompted adoption of the American style of OT (AOT), which already had a tentative foothold by the time study visits to Holland and Germany revealed the alternative methodology of MAT. Both methods were recommended by the Board of Control, but the establishment of a school of OT specialising in the American method in England in 1930 encouraged the use of AOT in English mental hospitals.

4.3.13 Conclusion

Patient work, as it had been organised in French and English mental hospitals before World War I, attracted criticism in both countries during the 1920s. There were accusations of exploitation on the one hand, and of enforced idleness on the other. New theories regarding therapeutic occupation emerging from the USA and Germany were promoted by enthusiasts in both France and England, but the responses varied. The divergent professional orientations of most French and English psychiatrists and their different training and professional networks, together with different financial circumstances and institutional

²⁶⁸ Hayward, *The Transformation of the Psyche*, 70-1.

²⁶⁹ Jones, "Aubrey Lewis, Edward Mapother and the Maudsley," 14.

infrastructures in the two countries, led to the promotion of OT in France being largely ignored by psychiatrists, and being embraced by the more progressive mental hospitals in England. Psychiatrists who adopted a psychobiological interpretation of mental disorder – mainly English psychiatrists, but also Édouard Toulouse and his Parisian colleagues – were more inclined to support the new methods of OT, while those who were wedded to a neurological or hereditarian interpretation, were less likely to adopt new methods based on a psychological approach. Any French interest in the new methods was unlikely to be translated into practice due to practical considerations such as nursing quality, overcrowding and financial concerns. How the new methods were received in Paris, Le Mans, London and Oxford is addressed in chapters five and six.

Chapter 5:

Patient Occupation in French and English Metropolitan Institutions

5.0 Introduction

The adoption of new methods of occupational therapy, or an adherence to more traditional methods of patient work, in the metropolitan institutions of Paris (the Asile Clinique and the Henri Rousselle Hospital) and London (the Maudsley and Bethlem Royal Hospitals), depended on several interrelated factors. The most important of these was the therapeutic orientation of the CMO or MS. In France, CMOs were more likely to be influenced by neurology, and an organicist approach to mental disorder, as French psychiatry was less well established as an independent discipline than English psychiatry. Establishing their scientific credentials by embracing new biological treatments was important to French CMOs anxious to assert their professional status. French CMOs had less authority than their English colleagues and standards of nursing were lower in France. English psychiatrists, on the other hand, were more inclined towards a holistic approach to mental disorder and were more open to psychological modes of treatment, including OT.

Other factors that influenced approaches to patient occupation were the patients' mental and physical condition, and their class and gender. These metropolitan hospitals specialised in acute cases, for which patient work had traditionally been considered unsuitable; bed-rest had been the preferred method of treatment for acute cases since the late nineteenth century. At the Parisian Asile Clinique, the neurological orientation of most of the CMOs and an ongoing belief that work was unsuitable for acute patients, meant that very few Asile Clinique patients worked, and OT (either AOT or MAT) was not adopted. Manual work was considered unsuitable for Bethlem's middle-class patients, although some patients (probably the lower-middle-class patients who did not pay fees) did work, but OT was introduced in 1932.

The significance of patient work to the hospital budget was another important factor. At the Asile Clinique, for example, chronic patients had to be drafted in to fulfil duties around the hospital that were considered unsuitable for acute patients. At the Henri Rousselle and Maudsley Hospitals, on the other hand, where MD Édouard Toulouse and MS Edward Mapother, took a holistic view of mental disorder, patients were encouraged to keep busy but the institution's finances did not rely on patient work. The organisation of art classes for patients suggest some form of OT was provided at the HRH, while at the Maudsley OT was introduced from the hospital's inception. The influence of local employment opportunities and new modes of working, however, was minimal. Rehabilitation depended less on the provision of vocational activities inside hospital than on access to support after discharge.

5.1 Levels of Professionalisation at Metropolitan Hospitals in France and England

5.1.1 The Institutions

Both the Maudsley Hospital and the HRH were based on the model of the general hospital, which was quite different to that of the asylum, which was subject to the prescriptive legislation of 1838 (France) and 1890 (England). The hospital model was focused on the active treatment of patients who were admitted, and could discharge themselves, voluntarily. General hospitals included facilities for teaching and research, laboratories for medical testing, outpatient departments, and social services.¹ This was the model to which those keen to reform the asylum systems in both France and England aspired.

In England, an enquiry launched by the London County Council in 1889 had recommended the “establishment of a hospital for the study and treatment of insanity ... that would produce increasing knowledge on the subject, and consequently of increased means of prevention and cure”.² No action was taken immediately, but the bequest made by Henry Maudsley in 1907 for the establishment of a hospital to focus on the “early treatment of cases of acute mental disorder ... to prevent the necessity of sending them to the county

¹ Postel and Quétel, *Nouvelle Histoire De La Psychiatrie*, 351.

² Cited in: Aubrey Lewis, “Edward Mapother and the Making of the Maudsley Hospital” in Aubrey Lewis, *The Later Papers of Sir Aubrey Lewis* (Oxford: Oxford University Press, 1979),138.

asylums” gave the LCC the impetus, and half the funds, to build the institution.³ Maudsley and his collaborator, Frederick Mott, believed that only by studying mental disorder at its early, acute, yet curable stage could useful knowledge be generated about the causes of mental disorder. They planned a hospital with facilities for postgraduate training based on Kraepelin’s clinic in Munich.⁴ When the Maudsley Hospital eventually opened in 1923, it was the only public mental hospital in England able to accept poor patients voluntarily. It was a hospital, not an asylum,⁵ with just 157 beds, plus research and teaching facilities and an outpatient department. Hospital patients were at liberty to leave the hospital on giving 24 hours’ notice, a freedom hitherto only enjoyed by patients of registered (such as Bethlem) and private mental hospitals.⁶ The Maudsley, which had been purpose-built, included areas for patient work and recreation.

The Maudsley was recognised as a Medical School, attached to the University of London, in 1924. By 1931, the hospital had become the principal teaching institution for the Diploma in Psychological Medicine.⁷ Its national pre-eminence was achieved with the arrival of distinguished Jewish émigrés, including William Mayer-Gross and Eric Guttman, from Nazi Germany, who boosted the Maudsley’s academic credentials.⁸ Ambitions to establish an Institute of Psychiatry at the Maudsley, thereby securing its reputation as an international centre of research, were thwarted first by funding difficulties (partially resolved by research grants from the Rockefeller Foundation) and then by the looming threat of World War II. The Institute was eventually founded at the Maudsley in 1948. The importance of OT within the Maudsley’s treatment repertoire, albeit as an adjunct to other medical and biological interventions in the late 1930s, reflected the link between adoption of OT and high levels of professionalisation.

It is interesting to note that London’s Bethlem Royal Hospital did not introduce OT until 1932, and then only after the pressure from the Board of Control. As a registered hospital, rather than a public asylum, Bethlem was able to accept both certified and voluntary

³ Edgar Jones, Shahina Rahman, and Robin Woolven, "The Maudsley Hospital: Design and Strategic Direction, 1923-1939," *Medical History* 51 (2007): 358.

⁴ *Ibid.*, 359-60.

⁵ Before 1930 in England, patients admitted to public asylums were certified, while hospital patients were not.

⁶ Jones, Rahman, and Woolven, "The Maudsley Hospital: Design and Strategic Direction," 363.

⁷ *Ibid.*, 375-6.

⁸ *Ibid.*, 376.

patients; it was the only hospital in the England, until the opening of the Maudsley in 1923, that specialised in acute patients (although unlike the Maudsley it did not accept paupers). This policy, initiated by the hospital Governors in the 1680s, had been reinforced by Physician Superintendent (PS) Charles William Hood (in post 1852-62) in the mid-nineteenth century, who stated that patients should be from the “educated classes in a presumably curable condition”.⁹ As the only hospital of its kind, and with a history dating back to the thirteenth century, Bethlem was a respected institution. In terms of teaching, Bethlem’s medical staff had given clinical demonstrations and taught at other hospitals since the mid-nineteenth century. The arrival of the Maudsley was perceived as a threat to its status, causing the PS, John Porter-Phillips, to expand Bethlem’s teaching programme and to apply for recognition as a school for the University of London. This was granted in 1924.¹⁰ A crucial difference between the courses offered at the Maudsley and at Bethlem was the emphasis on neurology at Bethlem. Links between Bethlem and the Hospital for Nervous Diseases at Queen Square were forged to establish a programme that embraced both neurology and psychiatry, and that stressed psychiatry’s connection with organic medicine.¹¹ This was at odds with the recommendations made by the Macmillan Report of 1926, which stressed the continuity of mental disorder (that is, an approach that took account of both physiological and psychological aspects of mental disorder). An organicist interpretation of mental disorder was unlikely to be favourable to the introduction of OT, a psychological treatment, which was only introduced in 1932.

Bethlem’s Medical School, whilst initially successful, had foundered by the late 1920s. This was partly blamed on the closure of its outpatient department, which provided “valuable material” for the teaching staff and enhanced the Medical School’s reputation, and partly on a lack of high-profile research.¹² The hospital’s move to rural Kent in 1930 further isolated the school and attendance fell away as competition from the Maudsley intensified. The DPM course therefore ceased to run after 1937.¹³ These factors led to Bethlem’s reputation being eclipsed by that of the Maudsley, where teaching and research (key indicators of

⁹ Andrews et al., *The History of Bethlem*, 649.

¹⁰ *Ibid.*, 572.

¹¹ *Ibid.*

¹² *Ibid.*

¹³ *Ibid.*, 573.

professionalisation) were at the forefront of its activities.¹⁴ An absence of OT facilities until 1932 was another indication that Bethlem was no longer at the cutting edge of psychiatry. Remarking on the absence of OT at Bethlem in 1931, the Board opined that “while this blank remains Bethlem cannot claim to be entirely up-to-date”.¹⁵

Like Bethlem, psychiatry at Ste Anne’s (including the Asile Clinique, the Faculty Clinic and the Admissions Service) was also heavily influenced by neurology. Long-standing plans¹⁶ to transform Ste Anne’s Asile Clinique into a hospital for acute, curable patients were resurrected in 1918. It was proposed that the Asile Clinique should provide the most up-to-date psychiatric treatment and care by doctors at the peak of their profession.¹⁷ The project was finally approved in 1923, although the transformation was not fully completed until 1927. Chronic patients were transferred to make way for acute cases. The men’s and women’s divisions were each divided into two sections, with their own medical and nursing teams for which additional staff were recruited. Central laboratories were established to serve the Asile Clinique and the suburban Seine asylums.¹⁸ The discharge rates after 1928 indicate a marked change in the movement of patients, demonstrating that the Asile Clinique was indeed operating as a service for acute, curable cases, as Dr Truelle observed in 1931.¹⁹ The neurological orientation of the CMOs meant that treatment was biological rather than psychological.²⁰

Directorship of the Faculty Clinic which opened in 1879 (attached to the Paris Medical Faculty) was consistently awarded to psychiatrists with a background in neurology, starting with Benjamin Ball (1833-1893) and including Alix Joffroy (1844-1908); Gilbert Ballet; Ernest Dupré (1862-1921); and Henri Claude (1869-1945).²¹ Gilbert Ballet, for example, was

¹⁴ Ibid.

¹⁵ Eighteenth Annual Report of the BoC 1931, 19.

¹⁶ Such plans were originally put forward in the 1870s and periodically resurfaced, including during the 1910s, but were not acted upon.

¹⁷ Dausset, Rapport Général, 1918, 20.

¹⁸ Nicolas Henckes, "Sainte-Anne Et La Psychiatrie Parisienne," in *L'hôpital Sainte-Anne: Pionnier De La Psychiatrie Et Des Neurosciences Au Coeur De Paris*, ed. Stéphane Henry, Catherine Lavielle, and Florence Patenotte (Paris: Somogy Éditions d'Art, 2016), 45.

¹⁹ Dr Truelle, Rapport de la 2e Section (Hommes), Asile Clinique, 1931, 13; Préfecture du Département de la Seine. ADP Périodiques 566-6.

²⁰ This is indicated in the Rapports Moraux de l'Asile Clinique of 1932-8. ADP/3719W 70-6.

²¹ Clarac and Boller, "History of Neurology in France," 645.

nominated chief of staff to neurologist Jean-Martin Charcot in 1882.²² Henri Claude was medical assistant to Fulgence Raymond (1844-1910), the neurologist who succeeded Charcot at the Salpêtrière Hospital. The clinic became a renowned centre for teaching and the location for many national and international conferences, despite the dilapidated state of its facilities which gave such a bad impression to foreign visitors, much to the embarrassment of Henri Claude.²³ Professor Claude and Dr Marie of the Asile Clinique were early adopters of malaria therapy for treating general paralysis of the insane (GPI), which came into use in 1923.²⁴ However, the clinic's strong neurological orientation did not prevent it from becoming the first French psychiatric institution to introduce psychoanalysis.²⁵ Claude devolved the practice of psychoanalysis to junior members of his staff with a special interest in this area, including Paul Schiff and Michel Cénac, who formed the new group *L'Évolution psychiatrique* in 1925.²⁶ In the 1930s they were joined by Jacques Lacan, well-known for his contribution to French psychoanalysis after World War II.²⁷ Although the Faculty Clinic was renowned for trialling new treatments (it was one of the first French institutions to trial malaria therapy), OT does not appear to have been amongst these new treatments, despite the clinic's nascent interest in psychoanalysis, and despite Paul Schiff's enthusiastic review of Hermann Simon's MAT in *L'Hygiène Mentale* in 1929.²⁸ This may have been due to a lack of skilled nurses, an issue about which Claude repeatedly complained.²⁹

Many CMO's of the Asile Clinique and the Admissions Service held an organicist interpretation of mental disorder, including Auguste Marie, whose 1926 report to the Prefecture focused on hereditary degeneration. He noted that those suffering from inherited, incurable conditions comprised the largest group of admissions to the Admissions

²² Pierre Vayre, "Gilbert Ballet (1853-1916): La Psychiatrie Raisonnée," *Histoire des Sciences Médicales* 41, no. 3 (2007): 263.

²³ Henri Rousselle, Rapport au nom de la 3e Commission sur l'Asile Clinique, CGS, 1923; 12. ADP/D.10K3/34/73.

²⁴ Dr A. Marie, Rapport du Service de l'Admission 1929, Asile Clinique, 8; Préfecture du Département de la Seine. ADP-PER-566-5.

²⁵ Clément Fromentin, Nicolas Dissez, and Luc Faucher, "La Psychanalyse À Sainte-Anne," in *L'hôpital Sainte-Anne: Pionnier De La Psychiatrie Et Des Neurosciences Au Coeur De Paris*, ed. Stéphane Henry, Catherine Lavielle, and Florence Patenotte (Paris: Somogy Éditions d'Art, 2016), 76.

²⁶ Ibid.

²⁷ Ibid., 77.

²⁸ P. Schiff, "Le mouvement d'hygiène mentale," 232-233.

²⁹ Rousselle, Rapport au nom de la 3e Commission sur l'Asile Clinique, CGS, 1923, 12.

Service.³⁰ A preference for biological treatments, associated with an organicist stance, was particularly noticeable after the Asile Clinique began to specialise in acute cases in 1927. Pharmacist Dr Levêque noted in 1928 that the amount of money spent on medicines had risen markedly since the new focus on acute cases, and that the constant evolution of biological treatments had resulted in an ever-increasing demand for new drugs, including sedatives, organotherapeutic medicines (drugs derived from animal organs, such as ovaries or thyroid glands) and anti-syphilitic medicines.³¹ There was no discussion in the reports of psychotherapy or psychoanalysis (despite the Asile Clinique's proximity to the Faculty Clinic) and the therapeutic benefits of patient work were rarely mentioned by the CMOs. The therapeutic environment at the Asile Clinique did not appear favourable to the adoption of OT and the evidence suggests that few patients worked.

Psychiatry at the Henri Rousselle Hospital (HRH), which opened in the grounds of Ste Anne's in 1922, appeared relatively free of the specialism's traditional close links with neurology. The HRH treated those suffering from mild symptoms of mental illness, including the psychological effects of war, and individuals affected by depression, anxiety, phobias and other neuroses.³² These conditions were sufficiently mild that patients were not subject to the law of 1838, and were free to enter or leave the hospital as they chose, just as in a general hospital. In this the HRH differed from the Asile Clinique, and from other French public asylums, where legal proceedings had to be undertaken prior to admission or discharge. The HRH formed part of a wider service, the *Service Libre de Prophylaxie Mentale* (or SLPM), which also comprised a dispensary (or outpatients clinic) for the external treatment of patients, eight separate research laboratories and an information department designed to educate the public on how to look after their mental health, as well as the hospital for patients whose condition required surveillance or continuous care, but not internment.³³ The SLPM was based on the model of a preventative service for mental conditions provided by the USA.³⁴

³⁰ Dr A. Marie, Rapport du Service de l'Admission, Asile Clinique 1926; 42. ADP-PER-566-5.

³¹ Dr M. Lévêque, Rapport du Pharmacien en Chef, Asile Clinique 1928, 102; Préfecture du Département de la Seine. ADP Périodiques 566-5.

³² Thomas, *Treating the Trauma of the Great War*, 152-3.

³³ Henri Rousselle, Rapport au nom de la 3e Commission sur le Service départemental et les services annexes, CGS, 1923; 6. ADP/D.10K3/34/87.

³⁴ Dausset, Rapport Général, 1918, 40.

Toulouse's commitment to research was indicated by his keenness to establish an Institute of Psychiatry and Mental Health within the SLPM. Bringing together the teaching and research initiatives of the Faculty Clinic (Professor Claude), the Faculté des Lettres (Dumas) and the HRH (Toulouse) was intended to raise professional standards within French psychiatry. The project was approved by the General Council in 1927.³⁵ By 1930, the Institute was organising conferences to promote research carried out within the various laboratories of the SLPM.³⁶ Lecture topics varied from epilepsy to paranoia in children, from schizophrenia to criminality and socialisation problems amongst the mentally ill.³⁷ Apart from the Asile Clinique, which also had its own research laboratories, few other French asylums were conducting research.

While OT is not specifically mentioned in the HRH reports to the Prefecture, and no statistics regarding the numbers of workers are given, the hospital accounts indicate that some HRH patients were being paid for working (the proposed budget for *les gratifications travailleurs* in 1929, for example, was 15,000FF).³⁸ Facilities were made available for patients to keep themselves occupied; sewing rooms, a piano and gramophone were provided, and local artists gave art classes to patients. This indicates that Toulouse was receptive to the idea of occupation for acute patients. The organisation of art classes suggests that he was aware of the American methods of OT that involved the teaching of arts and crafts to patients.

5.1.2 Therapeutic Orientation of the Medical Superintendents and Chief Medical Officers

Toulouse himself was an active social reformer, proposing reforms in all areas of French society, including politics; schools; sanitation; the status of women; criminality; the organisation of work; working conditions and career guidance; social welfare and housing; as well as mental hygiene.³⁹ He wanted to revolutionise society according to rational,

³⁵ Dr Toulouse, Rapport sur le fonctionnement et le développement de l'hôpital Henri-Rousselle, CGS, 1926-7; 120. ADP/D.10K3/42/91 Annexe.

³⁶ Dr Toulouse, Rapport sur le Centre de prophylaxie mentale et l'hôpital Henri-Rousselle, CGS, 1929-30, 131. ADP/D.10K3/46/78 Annexe.

³⁷ Dr Toulouse, Rapport sur Centre de prophylaxie mentale et l'hôpital Henri-Rousselle, CGS, 1930-31, 110-11. ADP/D.10K3/47/86 Annexe.

³⁸ Henry Grangier, Rapport au nom de la 3e Commission sur le Centre de psychiatries et de prophylaxie mentale Henri-Rousselle et les services annexes, CGS, 1928; 37. ADP/D.10K3/44/81.

³⁹ Huteau, *Psychologie, Psychiatrie Et Société Sous La Troisième République*, 31-7.

scientific principles; he wrote copiously and constantly lobbied the government.⁴⁰ Toulouse shared a conception of heredity as a cause of mental disorder with most other French psychiatrists. He believed that social; psychological; moral; physical and pathological factors could stimulate an inherited disposition towards mental illness. He did not believe, however, that mental illness itself could be transmitted through heredity. He was critical of such theories, held by French alienists, since they led to a fatalistic tendency to regard all mental illness as incurable. Toulouse was clear that mental illness was both curable and preventable.⁴¹ Influenced by contact with American psychiatry through the Mental Hygiene Movement, Toulouse adopted a more psychobiological stance after World War I and advocated psychotherapy for both in- and out-patients, as well as biological treatments, all of which were available at the SLPM. He expected his hospital patients to keep themselves busy, and ensured that the facilities were available for them to do so, but he did not mention “*ergothérapie*” or OT, like the MS of the Maudsley, Edward Mapother who first reported employing an occupational therapist in 1925.⁴²

Mapother’s beliefs underwent a similar ideological transformation during his career. His early papers (1911-14) were strongly neurological in tenor, despite having worked with some of the leading names in psychology (including Bernard Hart) at the Long Grove Asylum. But after World War I, he became interested in psychopathology and maintained that “in all properly investigated cases of insanity, it is found that it is the result of the summation of multiple causes, effective in combination, though inadequate singly”.⁴³ He declared futile the controversy between those who believed mental disorder had a psychogenic origin and those for whom its origin was physiological.⁴⁴ Mapother’s policy at the Maudsley Hospital was “to encourage an unprejudiced trial of every form of treatment offering a reasonable prospect of benefit rather than harm”.⁴⁵ He was sceptical about the efficacy of psychoanalysis, but accepted that the intensive methods used in psychoanalysis had contributed greatly to psychiatrists’ understanding of cases.⁴⁶ Despite his personal

⁴⁰ Ibid.

⁴¹ Ibid., 149-50.

⁴² MHR, 1925, LCC, 3. BMM/MSR-01.

⁴³ Thomas Bewley, "Online Archive 13: Edward Mapother (1881-1940)," in *Madness to Mental Illness: A History of the Royal College of Psychiatrists* (London: Royal College of Psychiatrists, 2008), 9.

⁴⁴ Ibid, 10.

⁴⁵ Ibid., 5.

⁴⁶ Ibid.

misgivings, Mapother made provision for psychotherapy at the Maudsley, justifying his actions by stressing the “continuity of all forms of mental disorder and for the compatibility of treatment ... of all grades of it”.⁴⁷ He acknowledged that psychotherapy was the most effective means of combating mental stress in cases of “functional disorder”, following his experiences in World War I. In this therapeutically tolerant atmosphere, OT, which had the advantage of doing no harm to patients (unlike many of the biological treatments of the 1930s) was able to flourish.

At Bethlem, although OT was not established until 1932, the PS, John Porter-Phillips’ support for (traditional) patient work was suggested by his remark concerning Bethlem’s move from South London to new rural premises in Kent. He saw the move as highly advantageous due to the “greatly increased facilities for natural treatment by means of exercise, recreation, and employment in the open air”.⁴⁸ The latter constituted a “great auxiliary to the medical treatment, particularly in those cases where the mental symptoms occur in late adolescence or early manhood”.⁴⁹ This work was probably only prescribed to convalescent patients, since the records indicate that sedation, bed-rest, a milk diet and hydrotherapy or electrotherapy were the preferred methods of treating acute patients during the interwar period at Bethlem.⁵⁰ Mechanical restraint was also used; the BoC inspectors noted in 1929 that two women had been mechanically restrained on 11 occasions for a total of 62 hours “to prevent self-injury”.⁵¹ All these other methods were denounced as old-fashioned by Aubrey Lewis in 1948.⁵² John Porter-Phillips’ initial focus on the “physical side of mental illness” (indicated by the Medical School’s neurological orientation and by his particular interest in focal sepsis), and the development of an interest in psychological approaches only in the late 1920s, delayed the introduction of OT until 1932.⁵³ Although supportive of OT once it had been introduced at Bethlem, Porter-Phillips remained committed to searching for physical causes of mental illness.⁵⁴ His expressed enthusiasm for manual labour in the open air, particularly for young men, was based on a

⁴⁷ Ibid., 11.

⁴⁸ BRH PS Report 1924, 20. BMM/BAR-52.

⁴⁹ Ibid.

⁵⁰ Andrews et al., *The History of Bethlem*, 680-1.

⁵¹ Sixteenth Annual Report of the BoC, 1929, 322.

⁵² Andrews et al., *The History of Bethlem*, 680-1.

⁵³ Ibid., 682.

⁵⁴ Ibid., 683.

view of patient work reminiscent of the moral therapist William Tuke's belief that the most "generally efficacious" type of employment was one that involved "considerable bodily action".⁵⁵ The economic value of the work performed at Bethlem was not mentioned.

5.2 The Financial Contribution of Patient Work

The financial contribution made by patient work to asylum and mental hospital budgets varied in its importance in France and England. In England, where budgets were not quite as stringent as those in France, the economic contribution of patient work was downplayed. A sharper focus on treatment and cure, following the influential Macmillan Report of 1926, led to a greater emphasis on the therapeutic properties of patient work and occupation and to wider acceptance of OT in England. In France, the greater economic pressures of the immediate post-World War I period and the more prolonged problems following the Great Depression increased the significance of the contribution to asylum running costs made by patient work.⁵⁶

5.2.1 The Financial Contribution: Paris

Reviewing the status of patient work in Seine asylums after World War I, General Councillor Dausset began by quoting the nineteenth-century moral therapist, Parchappe, who had declared, "I do not believe that it is against the principles of humanity, or morality, to expect the work of patients to make a profit for the establishments that offer them refuge".⁵⁷ Parchappe believed that it was perfectly legitimate to organise the work in "the double interest of patients and establishments".⁵⁸ Dausset felt that patient work was not sufficiently well organised in the Seine asylums. He observed that "a few women were employed in the laundry, in the ironing and sewing rooms, or in the kitchen, and that some men were engaged in cultivation or gardening, but the great majority of patients remained

⁵⁵ Samuel Tuke, *A Description of the Retreat: An Institution near York, for Insane Persons of the Society of Friends* [1813] (Charleston: BiblioLife, LCC), 156.

⁵⁶ Although the Great Depression began later in France than elsewhere, its economic effects were felt throughout the 1930s.

⁵⁷ Dausset, *Rapport Général*, 1918, 44.

⁵⁸ *Ibid.*, 44.

unoccupied in their quarters”.⁵⁹ Dausset recommended that the Seine asylums extended their use of market gardening, which required a much smaller area than agriculture.⁶⁰ From the economic point of view, this made sense because the products harvested could be consumed by the asylum population. From a therapeutic perspective, it offered employment to a large number of easily surveyed patients. While few Parisians were used to such work, the ability to grow their own fruit, vegetables and flowers was “a dream” for many, he claimed.⁶¹

Dausset hoped to see greater use made of asylum workforces. By 1925, the social care budget of the Seine department was overstretched. In the light of the escalating costs of maintaining the Seine’s mentally ill population,⁶² the General Council were looking at ways of reducing the paid asylum workforce of the Seine, so the work provided by patients was crucial.⁶³ This explains the hostile reaction of the General Council to a proposal to employ three kitchen assistants to replace patient workers at the Asile Clinique in 1925. The AD claimed that the kitchen was too dangerous for patients, but the Council argued that patients should be given tasks that were not dangerous, leaving the riskier work to existing employees. If every Seine asylum decided not to use patient labour in their kitchens, the cost implications of employing staff for them all would be huge (an estimated 170,000F).⁶⁴ Furthermore, patients were not to be denied the opportunity to work since it was a means of therapy. In the interests of both patients and budgets, it was recommended that kitchen staffing levels remained as they were, and that more effort was made to employ patients and to find safe work for them.⁶⁵

All the Seine asylums, including the Asile Clinique, had workshops, Dausset remarked, but the number of patients working in them had diminished each year.⁶⁶ The General Council emphasised that the profits from the workshops served to “lighten the maintenance costs

⁵⁹ Ibid., 45.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² Between 1924 and 1925 the maintenance costs rose by 11 million Francs and were set to rise by another 6.3 million in 1926.

⁶³ Chausse, Rapport Générale, 1925; 7.

⁶⁴ M. Béquet, Rapport au nom de la 3e Commission sur l’Asile Clinique: budget additionnel de 1926 et budget de 1927, CGS, 1926; 35. ADP/D.10K3/40/105.

⁶⁵ Ibid.

⁶⁶ Dausset, Rapport Général, 1918; 46.

which weighed so heavily on the collective purse”.⁶⁷ At the Asile Clinique, the workshops employed 25-45% of the patient workforce [see Table 4 below]. The work carried out in each of the workshops was monitored carefully, and the number of days worked by patients in each was (usually) recorded.⁶⁸ Workshop profits could not be attributed entirely to the use of patient labour, since the workshop managers and their employees worked alongside patients, but in some of the workshops, such as in the sewing rooms and laundry, patient workers considerably outnumbered staff.⁶⁹ Had paid staff been employed to fulfil patient duties the workshop accounts would have looked very different, despite the nominal amount paid to French patients for their labour (known as the *pécule*). The value of patient work to the Asile Clinique, referred to as the *produit du travail des aliénés* was evaluated as three times the total amount paid to patients. This *produit du travail*, together with the *produits recoltés*, the produce harvested from the market garden, represented the sums that the Asile Clinique stood to lose when the asylum was transformed into a hospital for acute patients, for whom work was considered unsuitable.

Table 4: This table shows the numbers of patients employed in the various workshops of the Asile Clinique 1922-37. Where no figures were given in the records, this is indicated with a question mark (no figures were recorded in 1931). The sewing workshops, Couture A and B, and the ironing workshop employed women, while the tailoring workshop and laundry employed both men and women (the breakdown is indicated in brackets). The other workshops employed only men.

Workshops	<u>1922</u>	<u>1923</u>	<u>1924</u>	<u>1925</u>	<u>1926</u>	<u>1927</u>	<u>1928</u>	<u>1929</u>
Gardens	7	9	10	12	12	?	7	?
Smoke House	1	1	1	1	2	?	2	2
Plumbing & Stonework	5	3	3	4	3	?	?	3
Carpentry	8	8	6	6	5	?	3	?
Locksmiths	10	6	7	8	7	“some”	?	?
Decorating & Glazing	2	3	3	3	3	?	2	?
Electricity	-	-	2	3	3	3	?	?
Mechanics	2	3	2	1	2	1	2	?
Laundry	11	12	13	12	16		17 (12:5)	22 (16:6)
Ironing	4	4	4	4	4	5	4	3
Shoe-making/repair	4	3	5	5	6	6	5	5
Tailoring	11	3	7	8	7	8	10 (9:1)	10 (8:2)

⁶⁷ François Latour, Rapport au nom de la 6e Commission sur les comptes du directeur de l’Asile Clinique et du receveur des asiles relatifs à la gestion de cet établissement en 1924, CGS, 1925; 20-1. ADP/D.10K3/38/75.

⁶⁸ Ibid.

⁶⁹ Tables AC-11 in the Appendices gives details of the numbers of days worked by patients, the *pécule* earned and the ratios of workshop staff to patient workers for the years 1922-34.

Couture A	10	10	11	11	10	11	13	12
Couture B	17	17	20	20	18	20	20	18
TOTAL	92	82	94	98	98	?	85 + ?	
Total No. Patient Workers	302	279	210	297	205	306	272	364
% Employed in Workshops	30%	29%	45%	33%	47%		c.31%	

Workshops	<u>1930</u>	<u>1932</u>	<u>1933</u>	<u>1934</u>	<u>1935</u>	<u>1936</u>	<u>1937</u>
Gardens	?	8	9	11	?	13	13
Plumbing	?	2	2	2	2	2	2
Heating & Stonework	?	3	2	2	1	1	2
Carpentry	?	4	5	4	4	3	4
Locksmiths	?	7	6	5	5	5	5
Decorating & Glazing	?	3	2	1	3	2	3
Electricity	?	2	3	3	3	3	4
Mechanics	?	1	1	1	1	1	1
Laundry	17 (13:4)	19	21	23	24	24	18
Ironing	4	5	6	6	5	6	6
Shoe-making/repair	3	3	3	3	4	3	2
Tailoring	9 (6:3)	4	4	5	6	6	5
Couture A	13	14	17	19	18	20	16
Couture B	18	24	27	30	?	29	23
TOTAL		99	108	115		118	104
Total No. Patient Workers	380	320	331	339	339	336	308
% Employed in Workshops		31%	33%	34%		35%	34%

The anticipated financial consequences of losing the Asile Clinique's workforce resulted in the repeated postponement of plans to transform the asylum to an acute hospital by the Administration. Proposals to create an acute hospital had been discussed at intervals since the early 1900s. Henri Rousselle, General Councillor of the Seine Department, had requested a feasibility study in 1913, but the war had intervened.⁷⁰ The project was finally approved in 1923, although only fully completed in 1927.⁷¹ Chronic patients and the

⁷⁰ Henri Rousselle, Rapport au nom de la 3e Commission sur les budgets et comptes de l'Asile Clinique, Conseil Générale de la Seine, 1915; 3. ADP/D.10K3/25/20.

⁷¹ Procès Verbal de la Visite de la Commission, 21-4 Avril 1923, Commission de Surveillance des Asiles Publiques d'Aliénés de la Seine, 1923; 122. ADP/D1X3-44/6.

intellectually impaired, who comprised the majority of the Asile Clinique's patient workers, were gradually transferred to colonies,⁷² or other asylums in the Seine or the provinces (where services were cheaper), to make room for the acute cases. To make up for the loss of these workers, the decision was taken to create a special division for chronic, working patients within the Asile Clinique, separate from the treatment sections.⁷³ Two pavilions were constructed for the 120 male and 50 female incurable patient workers who would be able to fulfil the tasks around the hospital that acute patients were deemed incapable of performing. After the transformation of the service in 1927, the contribution made by patient work became even more important because the acute hospital required the employment of two additional CMOs, four additional interns and 34 extra nurses to care for acute cases, whose salaries added to the maintenance charge.⁷⁴

The financial crisis of the early 1930s was another factor that added to the importance of the economic contribution made by patient work at the Asile Clinique. The departmental budget was particularly stretched as the cost of unemployment benefit rose from 1.5 million Francs in 1931 to 191 million in 1932 and was set to rise again to 210 million in 1933. Councillor Fiancette called for a reduction of 3 million Francs in the budget for maintaining the mentally ill of the Seine.⁷⁵ This demand was extremely challenging since the asylum population expanded during this period, adding to the costs of care.⁷⁶ A fall in the discharge rate was blamed on the economic crisis. Doctors hesitated to discharge recovered patients, because they would have struggled to support themselves in the exceptionally difficult economic climate of the early 1930s.⁷⁷ The economic crisis was therefore contributing to overcrowding in the Seine's asylums.⁷⁸ The increased costs of care, coupled with demands

⁷² Colonies for the Seine's chronic patients had been established at Dun-sur-Auron in 1892 and at Ainay-le-Château in 1897.

⁷³ The statistics given in the Asile Clinique's annual reports to the prefecture refer to the active treatment divisions (the men's first and second sections, and the women's first and second sections) rather than the workers' division.

⁷⁴ M.E. Chausse, Rapport au nom de la 3e Commission sur un projet de modification des cadres du personnel des asiles des aliénés, CGS, 1928, 2. ADP/D.10K3/44/63.

⁷⁵ Fiancette, Rapport Générale présenté au nom du Comité du budget, du compte et du contrôle, CGS, 1933; 6. ADP/D.10K3/49/64.

⁷⁶ The number of individuals passing through the Ste Anne's Admissions Service increased from 4,856 to 4,942, while the number of discharges from Seine asylums fell from 2,938 to 2,170 between October 1932 and October 1933.

⁷⁷ M.E. Chausse, Rapport Général au nom de la 3e Commission sur le compte du Service des Aliénés pour 1932, CGS, 1933; 4. ADP/D.10K3/50/110.

⁷⁸ *Ibid.*, 4.

for further cost-savings, increased the importance of patient work to the Asile Clinique budget. Re-organising the existing system of patient work to introduce MAT (or AOT) threatened to compromise the financial contribution made by working patients.

5.2.2 The Financial Contribution: London

The cost-savings made by patient work were also important to the English authorities before World War I, but after the war, the financial benefits of patient work were downplayed. The phrase “usefully employed” gradually disappeared from BoC and asylum reports, which emphasised therapeutic occupation rather than useful work. In the long-term it was deemed more cost-effective to incur the expense of employing an occupational therapist to oversee the application of therapeutic occupation that would expedite patient recovery and increase discharge rates.⁷⁹ This would enable greater numbers of patients to spend shorter periods in hospital and to re-join the labour market outside hospital more quickly. This argument was not put forward in France, presumably because occupation was not viewed as curative by the majority of psychiatrists, who were organicists.

Patient work was not discussed as a means of making financial savings in the immediate post-war era by the BoC. It is known that patients were working at Bethlem and the Maudsley, however, from the records produced by the Board’s inspection reports. Patient work at these hospitals was not evaluated in the same way that it was at the Asile Clinique, where the value of the work performed and that of clothing or food produced were recorded in the asylum budgets. The numbers of workers, the types of work carried out and the value of produce did not appear in the annual reports of the Maudsley or Bethlem hospitals. The Great Depression did not appear to stimulate the Board’s interest in the potential cost-savings to be made through patient work; the BoC were more focused on the therapeutic aspects of occupation as a means of speeding up recovery and discharge.

The Board emphasised its commitment to patient occupation “as a curative agent and as a means of promoting the contentment and well-being of [hospital] patients” in the Lunacy

⁷⁹ Eighteenth Annual Report of the BoC, 1928, 5.

section of its annual report of 1923.⁸⁰ The Board was critical of the provision of occupations for patients in most hospitals, noting that for many, the only available employment was ward work. The commissioners recommended the appointment of an occupations officer who would ensure that patient occupation was organised therapeutically.⁸¹ The BoC appeared to be distancing themselves from a pre-war pre-occupation with the monetary value of patient work in asylums, probably to avoid the accusations of exploitation made in Dr Lomax's 1921 book. The Board admitted in 1928 that, "in the past there has been a tendency to concentrate on the employment of those patients whose readiness to work was spontaneous ... and upon work which was of some economic value to the institution".⁸² In this 1928 report the Board highlighted the "gratifying results" obtained in some hospitals, such as the Maudsley, where "occupational therapy" had been developed.⁸³

In contrast to French attitudes towards patient work, the Board's *Memorandum on Occupational Therapy* (1933) maintained that "the economic value of occupation need not be stressed".⁸⁴ They noted that OT might result in improved general behaviour amongst patients and thereby reduce "the misuse and destruction of clothing and property", which would generate an indirect cost-saving, and that it might increase the patient's "capacity for useful work".⁸⁵ This constitutes a veiled acknowledgement that patient work did benefit the institution. Later in the *Memorandum*, when addressing patient work in the utility departments of the hospital, the Board emphasises that "the object of occupation is primarily therapeutic" and "not ... a means of providing commodities for use in the hospital at a low cost".⁸⁶ Since the work was supposed to be therapeutic, there should not be "too much stress ... laid on output and finish".⁸⁷ Patients were not to be expected to produce "articles of high artistic merit or of commercial value".⁸⁸ In some instances, the Board suggested that hospitals might find it cheaper to purchase goods, such as clothing or shoes,

⁸⁰ Tenth Annual Report of the BoC, 1923, 10. Following the 1913 Mental Deficiency Act, the Board's annual reports were divided into two sections, one dealing with "Lunacy" (or mental illness) and the other dealing with "Mental Deficiency" (or intellectual impairment). Work was discussed in much more detail in the latter section.

⁸¹ Tenth Annual Report of the BoC, 1923, 10.

⁸² Eighteenth Annual Report of the BoC, 1928, 4-5.

⁸³ Eighteenth Annual Report of the BoC, 1928, 4.

⁸⁴ BoC, *Memorandum on Occupational Therapy* (1933), 4.

⁸⁵ Ibid.

⁸⁶ Ibid., 7.

⁸⁷ Ibid.

⁸⁸ Ibid. 25.

from outside sources than to have patients make them in the workshops. This is indicative of the mass-market production of goods and the new techniques involved in their manufacture. In such cases, hospitals were encouraged to consider the benefits for the patient, rather than the small economy resulting from the purchase of the items.⁸⁹ Again, this is marked contrast to the French rationale for patient work, which was to benefit the institution as well as the patient.

Where the Board did take cost-savings into considerations was in the area of funding the craft activities of AOT. The Board maintained that “the best work can often be done with the simplest and cheapest materials”, so “no great outlay” was required. They recommended the use of waste materials, claiming that “a little ingenuity ... solves many problems”.⁹⁰ The cost of materials for handicrafts was usually covered by sales of the finished goods. This was certainly the case at Bethlem, where the PS was proud to announce in 1933 that the work produced by the OT department (established the previous year) had “found a ready sale amongst patients and their friends and articles to the value of £70 have been sold”.⁹¹ At the Maudsley, items produced by the OT department were sold in the hospital canteen, which also sold tobacco, sweets, stationary and toiletries to patients, visitors and staff.⁹² The MS was keen to point out in 1930 that OT continued to be run on a self-supporting basis (apart from the salary of the occupations officer). Patients who wanted to keep the items they made bought the materials themselves at a reduced price.⁹³ A special sale of work was organised in 1930 to reduce a previous deficit, but most of the funds to provide materials for OT came from the sale of goods from the canteen.⁹⁴ OT may not have been aimed at making a profit, but it was expected to cover its costs, an expectation that both Bethlem and the Maudsley sought to realise during the financially difficult years of the Depression. While patients also worked around the hospital, any financial benefit to the hospital was incidental and was not calculated or displayed in the accounts. This was in marked contrast to the situation in France, where the AD, who was responsible for hospital finances, recorded and evaluated all the hours worked by patients.

⁸⁹ Ibid., 25.

⁹⁰ Ibid.

⁹¹ BRH PS Report, 1933, 10.

⁹² MHR, 1924, 9.

⁹³ MHR, 1930, 16.

⁹⁴ Ibid.

5.3 The Authority of the CMO and MS

In France, as discussed in chapter four, management of the institution was shared between the AD and the CMO. Although the CMO held responsibility for medical matters, patient work was an area in which both the AD and the CMO had an interest, the first from an economic and the second from a therapeutic perspective. This management structure could lead to conflict. Conflict between the Asile Clinique CMOs and the AD was overt before World War I. The AD was reported by General Councillor Henri Rousselle in 1909, 1910 and 1913 as desperate for female patients to work in the Ironing Workshop.⁹⁵ He could not understand how, in an asylum of some 500 women, it was impossible to find five women capable of ironing, and he implored the medical staff to co-operate.⁹⁶ The origin of the CMOs' reluctance to supply patients for the workshop was not fully explained, but a lack of proper patient supervision by the workshop managers (who reported to the AD) was suggested.⁹⁷ While incidents such as this were not reported after World War I, similar tensions are likely to have existed as the management structure remained the same, even after amendments to the legislation regarding asylum management of 1937/8.

The necessity of the CMO having complete control over the work regime (without its being compromised by the different agenda of the AD) had been highlighted by the originator of MAT, Hermann Simon, and by others recommending his ideas, including the Parisian psychiatrist Jacques Vié.⁹⁸ Simon was well aware that the interests of administrators responsible for hospital finances were not always compatible with those of the physician, and that discord between the two camps could compromise patient well-being. He believed that medical direction of the hospital was essential for the successful introduction of MAT.⁹⁹ In Holland, where MAT had been established, Dutch psychiatrists had the authority to drive through reforms and introduce innovative new practices; this was lacking amongst their French colleagues.¹⁰⁰ Contrary to French tradition, at his own insistence and supported by General Councillor Henri Rousselle, Édouard Toulouse was "medical director"

⁹⁵ Henri Rousselle, Rapport au nom de la 3e Commission sur les budgets et comptes de l'Asile Clinique, CGS, 1909, 8; Rousselle, Rapport, 1910, 16; Rousselle, Rapport 1913, 12.

⁹⁶ Rousselle, Rapport 1909, 8. ADP/D.10K3/19/50.

⁹⁷ Ibid.

⁹⁸ Jacques Vié, "Le traitement des malades mentaux par le travail," *L'Aliéniste Français* 2 (1934):597.

⁹⁹ Ibid., 598.

¹⁰⁰ Porot, "L'assistance," 50-1.

of the HRH, responsible for both administrative and medical concerns. As the sole individual in charge of the SPLM, Toulouse was able to institute his priorities for patient occupation, for supporting patients at home and for giving work to those who were struggling during the financial crisis of the early 1930s. The SPLM, the only establishment of its kind in France at that time, was based on the general hospital model and was a far cry from that of the traditional French asylum.¹⁰¹ Concern was expressed by the General Council in 1935, when Toulouse retired, about maintaining the unique character of this “model institution” since it depended so much on Toulouse’s vision and energy.¹⁰² They were right to be concerned. Aubrey Lewis, when he visited Paris in 1937, noted that the HRH seemed “to have fallen away from its original achievements and potentialities [*sic*]”.¹⁰³ He remarked that although Génil-Perrin (Toulouse’s successor) was a “good clinician” he was not particularly interested in research or “change of any kind”.¹⁰⁴ This underscores the importance of the MS or medical director to the strategic direction and treatment priorities of a hospital, including the importance attached to patient work or OT.

In England, the BoC recognised the importance of the MS’s role in how a hospital was managed, remarking that this “depends more on the personality, the outlook and the experience of the Superintendent than on anything else”.¹⁰⁵ The MS was “the inspiration” behind the medical and scientific work of the hospital and needed to be the “physician in chief” and not just a good administrator.¹⁰⁶ In other words, if the MS or CMO believed that patient occupation was important, this would be prioritised (although the converse was equally true). It was up to the MS to make the necessary staffing and practical arrangements to facilitate OT. The BoC insisted that occupation should be directed by doctors and used throughout the hospital as “a socialising factor or as a method of cure”.¹⁰⁷ The Board were keen that medical officers “direct the course of OT in every phase”, watching the patients in their classes, the OT Centre, the gardens and recreational hall, or wherever they may be. They should study the effect of the treatment on different types of patients, using their

¹⁰¹ Postel and Quétel, *Nouvelle Histoire De La Psychiatrie*, 351.

¹⁰² René Fiquet, Rapport au nom de la 3e Commission sur le Centre de psychiatrie et de prophylaxie mentale Henri-Rousselle et les services annexes, CGS, 1934; 3-4. ADP/D.10K3/52/88.

¹⁰³ Lewis, "Report on Visits to Psychiatric Centres in Europe 1937," 81.

¹⁰⁴ Ibid.

¹⁰⁵ Nineteenth Annual Report of the BoC, 1932, 9.

¹⁰⁶ Ibid.

¹⁰⁷ BoC *Memorandum*, 15.

observations to prepare prescriptions to guide staff and “ensur[e] that every occupation and recreation is used therapeutically”.¹⁰⁸

At the Maudsley, while medical officers did not appear to become quite as involved in the OT activities as the Board advocated, “every patient [was] employed who [was] recommended by the Medical Officer”.¹⁰⁹ The MS of the Maudsley Hospital, Edward Mapother, favoured “established methods” of treatment and believed that occupation, in the context of a balanced hospital regimen, was important.¹¹⁰ Many of Mapother’s senior colleagues at the Maudsley (Thomas Tennent, Aubrey Lewis and Desmond Curran) had trained with Adolf Meyer, whose influential teaching emphasised occupation. Mapother’s own enthusiasm for occupation, together with that of his colleagues, help explain the Maudsley’s wholesale adoption of OT. At Bethlem, Porter-Philips’ focus on the physical aspects of mental disorder during the 1920s, and the subsequent development of interest in psychological approaches led to OT only being introduced at Bethlem in 1932.

5.4 The Quality and Quantity of Nursing and Other Non-medical Staff

The experience and level of professionalisation of the staff who oversaw patient work and occupation influenced the type of occupation that could be prescribed by psychiatrists. Mental nurses, who spent more time with patients on a daily basis than anyone else, had a significant impact on the management and treatment of patients in mental hospitals, and thus on patient work. In France, mental nursing failed to attract staff of a sufficiently high calibre to introduce the more sophisticated methods of occupation associated with OT. In Britain, OT emerged as a new profession during the interwar period, but this did not occur in France until after World War II. In both France and England, workshop managers, who had no formal training in dealing with the mentally disordered, supervised the patients working in the various hospital service department workshops. English and French institutions differed in that the workshop managers were supervised by the MS (a doctor) in England

¹⁰⁸ Ibid., 16.

¹⁰⁹ MHR of the MS, LCC, 1925;3. BMM MSR-01.

¹¹⁰ MHR, 1924; 8. BMM MSR-01.

and by the AD (an administrator) in France, who had different priorities. The MS was more concerned with therapy, while the AD's priority was efficiency.

5.4.1 Nursing Staff

In France, patient work was supervised by the nursing and general services' staff. Whether patients received adequate supervision or encouragement in their work depended on whether nurses had sufficient time, in addition to their regular duties, and had received the requisite training. In England, nurses in some mental hospitals were expected to support occupational therapists in the provision of OT or supervise occupation themselves in the absence of an occupational therapist.

5.4.1.1 Nursing in London

In England in 1924, the BoC's Committee on Nursing had expressed concern that approximately half of nurses employed in English mental hospitals were untrained or undergoing training, and that facilities for training varied considerably between hospitals. Their concerns were not levelled at the Maudsley Hospital, however, where the nursing care was praised in the Board's annual inspection reports. In 1926, the Board remarked that "everything is being done not only for the restoration to health but for the comfort of the patients".¹¹¹ The nursing care was described as "excellent" in 1935.¹¹² In 1923, the BoC noted that all the sisters and staff nurses were required to hold a certificate representing at least three years' training at a general hospital or a diploma from a recognised nursing school. All the sisters and most of the staff nurses also possessed experience at either mental or neurological hospitals.¹¹³ A nine-month course in handicrafts was established for nurses in 1935; nurses attended voluntarily in their free time. Thirty nurses had joined the two classes, for which craft teachers were supplied by the LCC.¹¹⁴ Maudsley nurses who underwent such training could therefore assist in the provision of OT for patients.

¹¹¹ Thirteenth Annual Report of the BoC, 1926, 145-6.

¹¹² Sixteenth Annual Report of the BoC 1929, 222; Twenty-second Annual Report of the BoC 1935, 484.

¹¹³ Tenth Annual Report of the BoC, 1923, 201.

¹¹⁴ Twenty-second Annual Report of the BoC 1935, 484.

In marked contrast to the Maudsley, where all senior nursing staff were qualified, at Bethlem, during the mid-1920s, approximately 65% of male nurses and 30% of female nurses were registered or certificated [see Table 5]. In 1934, the percentage of certificated nurses had fallen to 48% of male nurses, and 19% of female nurses.¹¹⁵ This suggested that nurse training was less of a priority at Bethlem. However, although nurses at Bethlem were not involved in instructing patients in OT, they were expected to encourage patients to take exercise and “to enter into amusements”.¹¹⁶ Bethlem’s “Rules and Orders”, prepared in 1932, stated that “the Nurses shall devote the whole of their time during the day to the Patients, and shall execute with diligence all the direction they shall receive respecting their treatment, medicine, food, dress, occupation, exercise and amusement”.¹¹⁷ There was no mention of patient work in the Rules, although this may have been included in “occupation”.

Table 5: This table shows the proportion of Registered or Certificated nurses and probationer nurses passing their final or preliminary MPA Nursing Examinations at the Bethlem and Maudsley Hospitals.

	Year	Total No. Nurses	Registered or Certificated	Passed Finals that year	Passed Prelims that year
Bethlem	1926	36 male 38 female	24 male = 67% 11 female = 29%	2	9
	1927	36 male 34 female	22 = 61% 11 = 32%	7	6
	1928	34 male 40 female	17 = 50% 14 = 35%	8 (4 men)	9 (1 man)
	1929	34 male	21 = 62%	5	10
	1933		51% male 10% female		
	1938	??	??	4	13
Maudsley	1923	62	100% senior staff		
	1929	86	11 male 43 female Total 54		19 out of 32 probationers

¹¹⁵ BRH PS Report, 1934, 20. BMM/BAR-53.

¹¹⁶ BRH Rules and Orders, 1932; 6. BMM.

¹¹⁷ Ibid., 10.

5.4.1.2 Nursing in Paris

Meanwhile, within the Seine asylums, nurses' salaries had been raised in an attempt to recruit competent, devoted staff who could give their patients the best care.¹¹⁸ Nurse training, while standards varied from school to school, was offered at all Seine asylums, and the school at Ste Anne's was regarded as one of the best. The length of training had been increased from one year to two in 1922. But this did not allay criticism of nursing in the Seine department. For the successful introduction of MAT, nurses needed to be highly trained and committed to their role, since, as Legrain and Demay highlighted in their 1934 report, the application of therapeutic work rested with the nurses.¹¹⁹ Nurses needed to have the skills to motivate patients, to direct the activity of distracted or confused patients, to intervene if a patient became agitated and to modify the work according to how a patient was coping. They needed to be familiar with their patients' conditions, interests and capabilities, and able to handle them with patience and tact.¹²⁰ French mental nurses, including those in the Seine department, lacked the training and experience to direct patient work effectively, particularly when dealing with more challenging patients.¹²¹

Doctors made frequent complaints about a lack of nurses. Although "on paper" there were sufficient numbers, in practice nurses were frequently required to leave the wards. This was partly related to the inadequate provision of facilities. Dr Marchand, for example, noted in 1931 that nurses had to take patients from the First Quarter, where there was no bathroom, over to the general baths, leaving acute patients unattended on the ward.¹²² One CMO of the Seine's Villejuif Asylum, the "sister" institution to Ste Anne's, claimed that "moral treatment" [*sic*] had become almost impossible since patient surveillance and routine tasks took up all the nurses' time and they had no time to talk to patients.¹²³ If nurses had no time to talk to patients, they were unlikely to have time to supervise patient occupation on

¹¹⁸ Chausse, Rapport Général au nom de la 3e Commission sur le compte du Service des Aliénés, CGS, 1925; 8-10. ADP/D.10K3/38/83.

¹¹⁹ D-M. Legrain and G. Demay, "Le travail des aliénés convalescents," 283.

¹²⁰ Ibid.

¹²¹ Demay, "Les conditions," 33.

¹²² Dr Marchand, Rapport de la 1ere Section des hommes, Asile Clinique, 1931; 93. ADP/PER-566-6.

¹²³ Maurice Quentin et Alphonse Loyau, Rapport Général au nom de la 3e Commission sur le compte du Service des Aliénés, CGS; 1936, 2. ADP/D.10K3/54/114.

anything other than a rudimentary level. Staff lacked the will, the resources, and the expertise to implement far-reaching changes to the way occupation was organised.

5.4.2 Occupational Therapists

One of the fundamental differences between French and English mental hospitals was the employment of an occupational therapist. In France, because the new approaches to OT had not been championed by CMOs, there was actually no need for occupational therapists to be employed. Patients work, organised in the traditional way, was supervised by the workshop managers, or by the nurses in the case of ward work. There were no opportunities to train as an occupational therapist during the interwar period (the first schools of OT (*ergothérapie*) opened in Paris and Nancy in 1954) and the position of occupations officer or occupational therapist did not exist in France at that time. Craft activities were not taught to patients at the Asile Clinique, although at the HRH local artists came to the hospital to give art classes to patients.

In England, during the early 1920s, the BoC encouraged every large hospital to employ an occupations officer to put the organisation of patient occupation “on a better footing”, and from 1933, a trained occupational therapist.¹²⁴ The latter should be someone with “considerable knowledge of the theory and practice of occupation therapy and who has the education and mentality to interpret the doctors’ instructions in the widest therapeutic sense”.¹²⁵ When the Maudsley first opened, patients confined to bed were given activities by the assistant matron, but she soon became “too busy”.¹²⁶ An occupations officer was therefore engaged in 1924. Her working hours were extended from three afternoons per week to five in 1925, and she became full-time in 1929.¹²⁷ She was assisted by seven volunteers during 1925, one of whom had trained as an occupational therapist in America.¹²⁸ In 1924, the MS claimed that patients were engaged in household duties, needlework, clerical work, gardening, carpentry and upholstery.¹²⁹ The occupational therapist also supervised the new OT centre that opened in 1931, where patients who were

¹²⁴ Tenth Annual Report of the BoC, 1923, 10; BoC *Memorandum*, 16.

¹²⁵ BoC, *Memorandum*, 16.

¹²⁶ MHR 1924, 9.

¹²⁷ MHR 1926, 6; Sixteenth Report of the BoC 1929, 222.

¹²⁸ *Ibid.*

¹²⁹ *Ibid.*, 8-9.

fit enough could carry out a wider range of crafts than those practised on the wards. The occupational therapist was assisted by OT students and nurses who also received training in OT.¹³⁰ Although there was only one occupational therapist employed by the hospital by 1936, patient occupation was also supervised by trained volunteers, nurses and students.

The Maudsley Hospital was one of three English institutions offering training in OT during the interwar period. Initially, it was offered on an informal basis. Those who wished to take up a career in supervising occupations for the mentally disordered could gain practical experience through working with the Maudsley's occupations officer, appointed in 1924.¹³¹ From 1932, the Maudsley offered a regular six-month course in OT in conjunction with the Royal College of Nursing; the course was extended to 12 months in 1935. Camberwell School of Arts and Crafts provided the technical training in weaving, rug-making, basketry, book-binding, cardboard construction, leather-work, sewing, embroidery and design.¹³² Nurses were also allowed to join some of the practical training. In this way, the nurses could become a "useful supplement to any possible provision for the instruction of patients by more highly skilled occupational therapists".¹³³ At Bethlem, the Physician Superintendent's report of 1936 indicated that "the training of new students in Occupational Therapy has become a regular feature of the Department" enabling "work to be done on a much wider field".¹³⁴ Bethlem did not become a recognised school of OT, suggesting that this training was carried out on an informal basis.

5.4.3 Workshop Staff

In England, occupational therapists were not involved with the work performed by patients around the hospital; their time was spent supervising ward activities and arts and crafts in the OT department. The BoC recommended the employment of one occupational therapist on "each side" (that is, the male and female sides) of a hospital for c.1,000 patients.¹³⁵ A therapist responsible for 500 patients would not have time to supervise work as well as arts and crafts. The supervision of patients undertaking office work, gardening or work in the

¹³⁰ MHR, 1936, 40.

¹³¹ MHR, 1935, 41.

¹³² Ibid.

¹³³ Ibid.

¹³⁴ Bethlem Royal PS Report, 1936, 10. BMM/BAR-53.

¹³⁵ BoC, *Memorandum*, 23.

kitchen at the Maudsley was not mentioned; it may have been the responsibility of nurses, or the regular hospital staff. There is no indication that the regular staff received any training, but all ultimately reported to the MS [see Table 6].

In France, Demay observed in 1929 that workshop managers, who reported to the Bursar and ultimately the AD, appeared unaware of the nature of mental illness and many showed neither kindness nor patience towards the patients working in their workshops.¹³⁶ They were overly concerned with productivity and failed to prioritise the therapeutic, re-educative purpose of patient work. Patients were sometimes excluded from workshops for being disruptive, or too placid, or for showing a “lack of respect” for an employee. Demay recommended (as Dr Marie had done in 1913) that each workshop manager should undergo a period of training in medical services. At the very least, the doctor needed to give the workshop staff precise instructions regarding the patients conferred to their care.¹³⁷ Between 25% and 45% of the Asile Clinique’s patient workforce were employed in the workshops [see Tables AC-11 in the appendices], so this daily interaction with workshop staff affected a significant proportion of working patients.

Table 6: Shows the categories of staff involved in supervising patient work/occupation, and to whom they reported, at the Asile Clinique and the Maudsley Hospitals. Ultimate responsibility for patient work lay with the AD (non-medical) at the Asile Clinique, and with the MS (medical) at the Maudsley.

Institution	Patients involved	Type of activity	Staff involved	Responsibility
Asile Clinique	Chronic and Convalescent patients	Workshops, Laundry and Kitchens, Gardens	Workshop, kitchen, laundry managers, head gardener	AD
	Acute	Ward work	Nurses	CMO
Maudsley	Acute – in bed	Crafts adapted for carrying out in bed	OT + nurses + volunteers	MS
	Acute – on wards	Crafts Ward work	OT + nurses + vols Nurses	MS
	Acute – getting fitter	OT Centre Ward work	OT + students Nurses	MS
	Convalescent	OT Centre Work around hospital	OT + students Hospital Staff (e.g. head gardener; cook)	MS

¹³⁶ Demay, “Les conditions”, 37.

¹³⁷ Ibid.

5.4.4 Staff-to-Patient Ratios

The ratio of staff to patients had a significant impact on how much time staff had to supervise patient occupation. This was particularly important in institutions where there were no occupation officers or OTs, such as the Asile Clinique. Ladame and Demay observed that in most French asylums there was usually one nurse to every ten patients.¹³⁸ This ratio was similar, according to the BoC to that of most English mental hospitals where the ratio was one nurse to nine or ten patients.¹³⁹ Ratios at the Bethlem and the Maudsley hospitals, however, were far better as indicated by the Tables 3a-f shown in chapter four, pages 94-5. Professor Claude complained in 1922 that nurse numbers at the Faculty Clinic were so inadequate, particularly during the holiday season, that he was unable to use his isolation rooms.¹⁴⁰ The Asile Clinique ratio improved following transformation into an acute hospital and the “doubling” of the services in 1927, resulting in one CMO becoming responsible for c.200 cases instead of 400, and the addition of 34 medical and nursing staff. These additional staff were recruited to provide the more intensive care required for acute patients undergoing biological treatment (such as malaria therapy) rather than to deliver MAT.¹⁴¹

Staff issues thus played a significant role in the adoption, or lack of adoption, of OT in French and English mental hospitals. The therapeutic preferences of the psychiatrist were crucial, but so too were his authority, and the means at his disposal to instigate those preferences. In England, the MS, who had sole responsibility for management of the hospital, had the authority to drive through the introduction of OT. Mental nurse training was more widely available in England, and standards were higher, particularly in the capital. In England, the new profession of “occupational therapist” emerged during the interwar period, for which formal training was available from 1930. Occupational therapists were supported by well-qualified nurses, trained in the basics of OT, at the Maudsley Hospital. Workshop managers at the Maudsley and Bethlem were ultimately responsible to the MS who could insist on a therapeutic agenda. In contrast, in France, the CMO shared responsibility with the AD. Even if both the CMO and the AD had opted to adopt OT, the

¹³⁸ Legrain and Demay, “Le travail des aliénés convalescents,” 283.

¹³⁹ Report of BoC’s Committee on Nursing in County and Borough Mental Hospitals, *JMS* Apr (1925): 292.

¹⁴⁰ Henri Claude, *Rapport de la Clinique des maladies mentales, Asile Clinique, 1922*; 95-6. ADP/PER-566-5.

¹⁴¹ The administration of malaria therapy, for example, was particularly labour-intensive.

quality and quantity of nurses would have inhibited such a move. Mental nurse training was poor in France and even in Paris, nurses lacked the education and commitment necessary for the successful introduction of OT. At the Asile Clinique, the workshop managers who supervised c.30% of the patient workforce, reported to the AD, rather than the CMO, and were not always sympathetic to patient needs. In short, management issues, staff quality and quantity made the introduction of OT more feasible in English than French institutions.

5.5 Patient occupation in the context of other treatments

The treatment preferences of psychiatrists, together with the aptitudes and numbers of mental nurses, affected the provision of all forms of treatment, including patient work, OT, physical and biological treatments. Many psychiatrists preferred to offer biological treatments in keeping with their desire to appear scientific, while others were more cautious of methods whose efficacy had not been fully proven, such as the new “shock” treatments emerging in the 1930s.

5.5.1 “Established Methods” of Treatment: 1918-1925

During the 1920s, as Jones *et al.* emphasise, psychiatrists had “little to offer in the way of treatment”.¹⁴² In 1918, the French Asylums Medical Society, led by Toulouse, identified “modern treatment” as comprising hydrotherapy, isolation, UV-ray treatment, electricity, radiography, psychotherapy, work and distractions.¹⁴³ In 1925, Mapother, MS of the Maudsley, observed that “In spite of any modern advances, it may be said that certain long established measures still form the foundation of any successful treatment of neuroses and psychoses” and that “suitable feeding, fresh air and sun, the regulation of rest, exercise and occupation, the procuring of sleep, are indispensable conditions”.¹⁴⁴ Mapother recognised the need to “elucidate both recent and remote sources of mental trouble” through psychotherapy but felt this was better achieved after the patient’s emotional state had been improved by the established measures, and by the removal of the patient from home, which was often at the heart of a patient’s anxieties.¹⁴⁵ Other treatments included massage and

¹⁴² Edgar Jones, Shahina Rahman, and Brian Everitt, “Psychiatric Case Notes: Symptoms of Mental Illness and Their Attribution at the Maudsley Hospital, 1924-1935,” *History of Psychiatry* 23 (2012): 163.

¹⁴³ Dausset, “Rapport Général,” 1918; 23-29.

¹⁴⁴ MHR, 1924, 8.

¹⁴⁵ Ibid.

remedial exercises; electricity in the form of galvanism, vibro-massage and sinusoidal baths; bed-rest and hydrotherapy. Work and occupation were considered an essential part of a balanced regimen.

5.5.1.1 Hydrotherapy

In England, the BoC noted that the “restorative power of warm baths” had long been recognised in the treatment of mental disorder. Baths were regarded as “powerful therapeutic agents” for their “sedative effect in allaying irritability and controlling excitement” and “their soporific influence in insomnia”. Hydrotherapy facilities were available at the Maudsley but were lacking at Bethlem, where “other methods for the treatment of such conditions as acute excitement and insomnia” were favoured, as the BoC observed.¹⁴⁶ This point was not elaborated, but a number of Bethlem patients were restrained or placed in isolation cells, according to the BoC inspectors’ reports. For example, in 1926, “one [patient] of each sex has been mechanically restrained on forty-five and fourteen occasions respectively”.¹⁴⁷ While hydrotherapy was provided at the HRH, at the Asile Clinique the facilities were unfit for purpose, an observation made repeatedly both before and after the war. Professor Claude of the University Clinic described the situation as detrimental for patients and a source of embarrassment when foreign doctors visited the clinic.¹⁴⁸

5.5.1.2 Medicinal Treatments

The increased use of medicinal treatments during the 1920s at the SLPM and at the Asile Clinique is indicated by the rise in expenditure on medicaments. Pharmacy costs rose by 15,000F between 1921 and 1922 to 58,000F.¹⁴⁹ Half of the 86,000F spent in 1924 was attributable to the Toulouse’s SLPM. An even more significant rise to 140,500F in 1927 followed the splitting of the Asile Clinique services, allowing doctors to devote more attention to “active treatment”.¹⁵⁰ In 1928, the pharmacist remarked that not only was the cost of medicines rising, but so was their use by the various services within Ste Anne’s.¹⁵¹ By

¹⁴⁶ BRH PS Report 1923, 23.

¹⁴⁷ Thirteenth Annual Report of the BoC, 1926, 262.

¹⁴⁸ Claude, Rapport de la Clinique, 1922, 96.

¹⁴⁹ Dr Thabuis, Rapports du Pharmacien en Chef, Asile Clinique, 1921, 71; and 1922, 101. ADP/PER-566-5.

¹⁵⁰ Dr Thabuis, Rapport du Pharmacien en Chef, Asile Clinique, 1927; 77. ADP/PER-566-5.

¹⁵¹ M. Lévêque, Rapport du Pharmacien en Chef, Asile Clinique, 1928; 102. ADP/PER-566-5.

1929 pharmacy expenditure had increased to 200,800F, of which 123,900F related to medicines for the Henri Rousselle Hospital, including organ extracts, hypnotics, barbiturates and anti-syphilitic drugs.

At Bethlem, all patients, whatever their condition, were sedated on admission. This custom had been established by the then PS, Rhys Williams, in the late nineteenth century. The drugs used included sulphonal (a powerful tranquilizer developed in the 1880s) and paraldehyde.¹⁵² In contrast, at the Maudsley, Mapother reported that sedatives were “sparingly used” and that every effort was made to substitute hydrotherapy or other means where possible. The drugs administered, when necessary, were paraldehyde, dial and amylene hydrate.¹⁵³ In 1926, Mapother indicated that pyrexia (fever therapy) and tryparsamide was being trialled to treat neurosyphilis with some effect; colossal manganese for depression (no effect); afenil for dementia praecox (positive results); ergot for symptoms of anxiety, headache and tinnitus (some effect); somnifen for calming seriously agitated patients (effective); belladonna for encephalitis (producing only slight improvement); bulbocapnine and apocodeine for tremors (minimal effect). Apart from occupation, regulated rest and the “hygiene of hospital life”, psychotherapy was found to be the “most important measure” in the majority of cases.¹⁵⁴ The longer that psychotherapy could be continued, the more positive the results. Adjustment of the patient’s social situation on discharge, with the assistance of the Lady Almoner, was considered “invaluable”.¹⁵⁵ The variety of these treatments, which took account of the patient’s physiological, psychological and social conditions, show that mental disorder was being treated “psychobiologically” at the Maudsley and indicate that occupation was an important aspect of the therapeutic mix.

5.5.2 Treatment 1927-36

Treatment of GPI with malaria therapy and Stovarsol, an arsenic-based drug, at the Asile Clinique, following the doubling up of the Asile Clinique’s services in 1927, was reported to have enabled several patients to take up work once more, either within the hospital as convalescent patients, or after discharge. In 1928, for example, Dr Leroy reported that eight

¹⁵² Andrews et al., *The History of Bethlem*, 679.

¹⁵³ MHR 1924, 8.

¹⁵⁴ MHR 1926, 10.

¹⁵⁵ Ibid., 10.

of his GPI patients had been able to leave the asylum in a condition that allowed them to re-enter *la vie sociale* and take up their professions once more.¹⁵⁶ In the women's first section, which became the Malaria Therapy Centre in 1930, 20 patients were discharged "cured" and were able to return to work.¹⁵⁷ In 1935, Dr Marchand discharged four more GPI patients from the Men's First Division, following treatment with Stovarsol, who were then able to return to productive work.¹⁵⁸ After discharge, GPI patients who had been treated with malaria therapy or Stovarsol as patients of the Asile Clinique continued to receive treatment (twice or three times per week) at the dispensary of the SLPM, under the therapeutic direction of Dr Barbé.¹⁵⁹ GPI patients were not admitted to the HRH and the Maudsley, so the malaria treatment breakthrough did not affect these hospitals.

Only a few GPI patients were admitted to Bethlem and Porter-Philips was not enthusiastic about malaria therapy, believing it only offered "a slight hope of complete cure".¹⁶⁰ At Bethlem in the 1930s, patients continued to be sedated, with hyoscine prescribed to deal with head-banging and other destructive habits. Barbiturates, such as the hypnotics veronal and medinal, were increasingly used at this time to calm patients and promote sleep. Depressed patients were prescribed stimulants, including Benzedrine, that produced a sense of euphoria.¹⁶¹ Staff often ignored the complaints of patients that the drugs made them feel "drunk" and relied on sedation to keep patients calm and manageable.¹⁶²

5.5.3 Treatments introduced 1936-39:

The discovery of insulin shock treatment for schizophrenia in Vienna in 1936 generated international excitement at a time when the BoC were starting to despair of ever seeing "any noticeable improvement in the discharge rate".¹⁶³ The procedure was not without risks, however, and the following year, an alternative, safer method of shock treatment, by injections of the drug Cardiazol, was introduced. Cardiazol became the most widely used somatic treatment for schizophrenia and affective disorders in British public mental

¹⁵⁶ Ibid.

¹⁵⁷ Dr Leroy, Rapport de la 1re section des femmes, Asile Clinique, 1932; 76. ADP/PER-566-6.

¹⁵⁸ Dr Marchand, Rapport de la 1re section des hommes, Asile Clinique, 1935; 90. ADP/PER-566-6.

¹⁵⁹ Ibid.

¹⁶⁰ Andrews et al., *The History of Bethlem*, 684.

¹⁶¹ Ibid., 679.

¹⁶² Ibid.

¹⁶³ Twenty-third Annual Report of the BoC 1936, 2-4.

hospitals.¹⁶⁴ Unlike most asylum psychiatrists, Mapother was sceptical about the new shock treatments.¹⁶⁵ Until their efficacy could be proven, he opposed their use, while other psychiatrists (particularly in France) were keen to show that psychiatry was (finally) producing effective cures. Clinical trials of Cardiazol were banned at the Maudsley because convulsion therapy could cause anxiety and fear. Similarly, Mapother delayed the introduction of insulin coma therapy until November 1938 owing to the medical risks posed to patients.¹⁶⁶ While these shock treatments were being greeted with caution by Mapother, OT provision was expanding at the hospital, following the department's relocation to larger quarters after the hospital was extended in 1936. That year, a male occupation officer was appointed to provide carpentry classes for male patients; a dedicated carpentry workshop was planned for the hospital's second extension in 1939.¹⁶⁷

At Bethlem, Porter-Phillips referred to the "physiological shock" treatments as falling into the category of "experimental treatment".¹⁶⁸ He observed that "each method after trial appears to be withdrawn in favour of some other therapeutic agent more suitable and promising".¹⁶⁹ The results of insulin shock treatment delivered at Bethlem left him unconvinced, but he conceded that such treatment led to a definite alteration in the mental state or attitude of patients which made their management by the nurses much easier.¹⁷⁰ This was also noted by the BoC inspectors who recorded that no seclusion or mechanical restraint had been used in the previous 12 months.¹⁷¹ At this time, Bethlem's OT department was also expanding and attracting increasing numbers of patients; in 1936 a new sports pavilion was constructed.¹⁷²

In France, insulin shock treatment and Cardiazol were used in all the services of the Asile Clinique in 1938.¹⁷³ The judicious application of shock treatments was responsible for a "considerable reduction" in the length of a patient's stay in hospital, which was good for the

¹⁶⁴ McCrae, "A Violent Thunderstorm," 67.

¹⁶⁵ Jones, Rahman, and Everitt, "Psychiatric Case Notes," 121.

¹⁶⁶ Ibid.

¹⁶⁷ Twenty-third Annual Report of the Board of Control, 1936, 490.

¹⁶⁸ Bethlem Royal PS Report 1938, 6. BMM/BAR-53.

¹⁶⁹ Ibid.

¹⁷⁰ BRH PS Report 1938, 6. BMM/BAR-53.

¹⁷¹ BRH PS Report 1938, 26. BMM/BAR-53.

¹⁷² Twenty-third Annual Report of the Board of Control, 1926, 453.

¹⁷³ Asile Clinique Rapport Moral, 1938, 17. ADP/3719-W74.

patient (who could convalesce at home) and for departmental finances.¹⁷⁴ Treatment of GPI with malaria therapy and arsenic had continued, apparently with good results. Dr Guiraud had noted, by following patients' progress since 1934, that the results were not transitory, but definitive in most cases provided the treatment was continued for a long period after discharge.¹⁷⁵ UV-ray and electrical treatment had also been continued.¹⁷⁶ The report was optimistic, suggesting that the increasingly varied treatment offered at the Asile Clinique emphasised its role as a "proper hospital", where all acute patients were given appropriate care.¹⁷⁷ In the same report, however, the patient workforce was described as "practically non-existent" (*à peu près nulle*). The work of the general services and technical departments had been performed by the permanent and auxiliary personnel, rather than by patients.¹⁷⁸

This comment is surprising since the number of patient workers did not dip below 300 at any point during the 1930s, and the average number of workers during the decade was 328.¹⁷⁹ The average number of days worked was c.117,500 per annum and at no point did this figure drop below 113,000 days. That said, the number of patients workers in 1937 was below average at 308 (the figure for 1935 had been 339), but the number of days worked was above average at 118,656.¹⁸⁰ But even in 1934, when working patients numbered 331 and days worked 119,949, a comment was made about the diminishing number of patient workers, which made the service departments' productivity very difficult to predict.¹⁸¹ One explanation for this might be that the 150-160 patient workers from the treatment divisions did not perform what was considered useful work. Their period of convalescence may have been so brief that they were unable to master the skills required to contribute productively.

In England, it seems that occupation remained an important aspect of treatment throughout the interwar period despite the introduction of malaria therapy in the 1920s and various "shock" treatments in the late 1930s. Mapother's therapeutic conservatism, and Porter-Philips' scepticism may have contributed to their on-going support for less risky

¹⁷⁴ Ibid., 17.

¹⁷⁵ Ibid., 17.

¹⁷⁶ Ibid., 10.

¹⁷⁷ Ibid., 17.

¹⁷⁸ Ibid., 18.

¹⁷⁹ Asile Clinique Rapports Moraux 1932-1939. ADP/3719-W68-W76.

¹⁸⁰ Ibid.

¹⁸¹ Asile Clinique Rapport Moral 1934, 15. ADP/3719-W70.

treatments, such as OT. The latter, as opposed to traditional patient work, was itself innovative and was heavily promoted by the BoC. The provision of OT was expanding at metropolitan institutions during the interwar period, despite the introduction of biological methods. As Micale suggests, enthusiasm for shock treatments and other biological methods was a sign of desperation among psychiatrists who were aggressively attempting to “embrace the medical mainstream”.¹⁸² In France, where psychiatry was less well established as an independent discipline, this desperation was particularly marked. Acute patients at the Asile Clinique (after 1927) were not given the opportunity to engage in OT in the English sense of the term and at the HRH, while all patients were encouraged to keep themselves occupied, the emphasis was on biological treatments that would enable patients to leave hospital and to continue with their former professions. The return of patients to society and the labour market was particularly important in France, where there was a labour shortage following World War I and a low birth rate.

5.6 Patients and the Allocation of Occupation

5.6.1 Class and Gender

Whether patients were working-class or middle-class, private or pauper, affected whether they were expected to work, irrespective of their physical or mental condition.

Establishments catering for a middle-class clientele, such as Bethlem, had fewer working patients than public institutions, despite the alleged therapeutic benefits of work, because manual work was not considered appropriate for the middle-classes. Furthermore, an increasing proportion of Bethlem’s patients were paying full or part fees, and 25% of Maudsley patients were fee-paying, which may have led to a belief that they were exempt from contributing to the management of the institution. The class differences between patients at Bethlem and the public part of the Maudsley, although not as marked as might be expected between a registered and a public institution, led to the provision of different types of patient occupation.

Bethlem, as a registered hospital, catered for the poorer middle classes who could not afford the high fees of a private institution, but who could still afford to pay for their treatment, and the “deserving poor”, who were received “gratuitously”. As Andrews

¹⁸² Micale, "The Psychiatric Body," 336.

deduced from the rather patchy information regarding previous employment in the patient admissions records, there was “a preponderance of patients from the middle and upper ranks of society”.¹⁸³ Porter-Phillips noted that admissions in 1921 included “many professional men, officers of Her Majesty’s Forces and civil servants”.¹⁸⁴ In the early 1920s, c.70% of patients were received gratuitously (the “deserving poor”), but by the late 1930s, the figure was down to c.20%, suggesting that the profile of Bethlem patients became progressively middle class during the interwar period. It is plausible to assume patient work decreased as a result, while occupation in the form of OT and entertainments increased [see Table 7]. As Andrews has suggested, “Work did not agree with the Hospital’s bourgeois character”.¹⁸⁵ The records indicate that patients did work,¹⁸⁶ but the emphasis, in terms of patient occupation, was on leisure and entertainment, and on OT after 1932.

Table 7: This table indicates the numbers of patients who were “usefully employed”; who participated in Bethlem’s entertainments’ programme; and who attended the OT department (after its opening in 1932).

Year	Usefully employed	Entertainments	Patients attending the OT department (opened 1932)
1919	NM	“fairly well attended”	
1920	65 (45:20)	80	
1921	NM	NM	
1922	62	84	
1923	NM	NM	
1924	“very satisfactory”	“very satisfactory”	
1925 – June / Nov	75 – June 58 – Nov	85 – June 79 – Nov	
1926 – Nov	NM	75 (35:40)	
1927	NM	70 (35:35)	
1928	62	80	
1929	NM	75 (35:40)	
1930#	NM	NM	
1932	NM	NM	36 (14:22)
1933	NM	NM	179 (106:73)
1934	NM	86 (40:46)	203 (121:82)
1935	NM	110	306
1936	NM	NM	325
1937	NM	NM	335 (238:97)
1938	NM	NM	355 (265:90)
1939	NM	NM	317 (234:83)

NM = not mentioned

¹⁸³ Andrews et al., *The History of Bethlem*, 659-60.

¹⁸⁴ BRH PS Report, 1921, 7.

¹⁸⁵ Andrews et al., *The History of Bethlem*, 689.

¹⁸⁶ Between 30% and 35% of patients were recorded as “usefully employed” by the BoC’s inspectors 1919-28; after 1928 figures for “useful employment” ceased to be recorded (see Table 7 above).

The Maudsley was a public hospital, where c.75% of patients were rate-aided and c.25% paid fees [see Table 8 below]. There was no indication that work or OT was allocated differently between the classes, or between the private patients and those whose care was paid for by the LCC, but if the teaching of AOT was being followed, patient preferences would have been taken into account. All patients (with the exception of children under 14 years, who comprised 3-7% of Maudsley patients) were obliged to undertake some form of ward work as soon as they were able to get out of bed.¹⁸⁷ The handicrafts introduced at the Maudsley were aimed at making useful items for the hospital, such as wireless sets and other items of furniture.¹⁸⁸ Although admission was determined solely on medical grounds, and not by “social or financial considerations”, Maudsley patients included a high proportion of middle-class individuals, including educated professionals, such as doctors, clergymen and school teachers.¹⁸⁹ The largest professional group were artisans (26%), while the next most highly represented group were the unemployed (15%) [see Table 9 below].¹⁹⁰ The MS was aware of the wide range of social classes and educational attainment amongst patients, although such “social differences have never given rise to difficulties”.¹⁹¹

Table 8: This table shows the numbers of Maudsley patients who were rate-aided or fee paying, indicating whether adult or child; the average number of patients resident daily; and the average length of stay (in days) for the period 1923-1931.

Year	Adults under treatment	Children under treatment	Total under treatment	Rate-aided	Paying full cost	Average No. resident daily	Average duration (days)
1923	454	8	462	349	113 = 24%	116	91.6
1924	556	34	590	512	78	139	113.6
1925	646	42	688	582	106	142	93.9
1926	652	45	697	554	143	148	90
1927	773	24	797	602	195 = 24%	157	88.8
1928	757	39	796	543	253	171	95.8
1929	713	34	747	528	219	172	108.6
1930	729	40	769	541	228	170	102.1
1931	743	53	796	570	226 = 28%	184	109.5

¹⁸⁷ MHR 1926, 5.

¹⁸⁸ MHR 1924, 8.

¹⁸⁹ MHR 1926, 5.

¹⁹⁰ MHR 1926, 2.

¹⁹¹ MHR 1924, 6.

Table 9: This table shows the occupation of Maudsley patients prior to admission in 1925:

Professionals*	123 = 13%
Clerks	99 = 10%
Hospital nurses	16
Farmers	6
Shopkeepers	93 = 10%
Policemen, postmen and transport workers	57
Artisans	243 = 26%
Domestic servants	78
Labourers	91 = 10%
Unemployed	138 = 15%
TOTAL	944
* Professionals comprised:	
Doctors	9
Engineers	9
Teachers	6
Clergymen	5
Naval officers	3
Army officers	2
Artists	2

Unlike at Bethlem and the Maudsley, at the Asile Clinique, all patients were from the pauper class; the asylum did not receive private patients.¹⁹² Patients were therefore expected to work if they were sufficiently fit. Details regarding the previous occupations of patients passing through the Admissions Service (15% of whom were admitted to the Asile Clinique) reveal that over 45% of patients had no previous profession [see Table 10 below]. That said, it must be recognised that some of the individuals described as having “no profession” may simply have been unable to communicate how they were employed before becoming ill. A considerably higher proportion of women than men were unemployed prior to admission. This was particularly marked during the early 1920s, reflecting the government’s post-war pronatalist policies which encouraged women to stay at home and have large families.¹⁹³

¹⁹² Patients who could afford to pay fees went to private asylums, or *maisons de santé*.

¹⁹³ William Fortescue, *The Third Republic in France 1870-1940: Conflicts and Continuities* (London and New York: Routledge, 2000), 152.

Table 10: This table shows the numbers and percentages of patients admitted to Seine asylums (of whom c.15% were sent to the Asile Clinique) who were unemployed prior to admission:

Year	Men	Women	Total
1919	671 = 56%	1,548 = 77%	69%
1923	1,145 = 67%	1,527 = 76%	72%
1926	1,043 = 62%	1,448 = 77%	70%
1929	886 = 48%	1,471 = 66%	58%
1933	678 = 33%	1,432 = 60%	48%
1936	517 = 21%	1,936 = 63%	45%
1938	842 = 32%	2,081 = 65%	50%

Among those who were employed (and could articulate their profession) between 1919 and 1926, industrial work formed the largest employment category (11%-19% of men and 7%-9% of women), followed by clerical work for men (5%-9%) and domestic service for women (5%-7%) [see Table 11 below].

Table 11: The table shows the sectors in which Seine patients were employed prior to admission to one of the Seine's six asylums (of which the Asile Clinique was one) during the period 1918-1926:

	1919 M	1919 W	1923 M	1923 W	1926 M	1926 W
Liberal professions	27	19	24	-	32	10
Industry – bosses	1	-	2	-	17	2
Industry – workers	225 (19%)	188 (9%)	283 (17%)	194	178 (11%)	124 (7%)
Farmers	18	4	15	-	13	-
Property owners	9	6	7	14	37	16
Beveridge trade – bosses	4	3	13	-	31	9
Beveridge trade – workers	2	-	6	-	42	12
Other trades	26	9	18	4	67	15
Travelling salespeople	-	1	5	7	9	4
Employees of business and administration = clerical	107 (9%)	62	115 (7%)	40	84 (5%)	35
Military/nurses/wardens	10	10	4	4	13	6
Domestic servants	28	95 (5%)	25	143 (7%)	31	127 (7%)
Day labourers	59	73	45	60	93	75
Religious/clerical	-	1	2	-	-	2
Without profession	671 (56%)	1,548 (77%)	1,145 (67%)	1,527 (76%)	1,043 (62%)	1,448 (77%)
TOTAL	1,187	2,019	1,709	2,001	1,690	1,885

Between 1929 and 1938, industrial work remained the largest category of employment for men (apart from in 1933 when it was marginally surpassed by day-labouring) employing between 18% and 29% of male patients. Clerical work employed between 7% and 13% of male admissions. Amongst the women, the employment categories were more evenly spread between domestic service, needlework, clerical work, day-labouring and industrial work, each employing roughly 3-5% of female admissions. [see Table 12 below]. These roles were typically working-class and contrasted with the blend of middle-class and skilled working-class professions of Maudsley patients. Only 15% of Maudsley patients were described as unemployed, but this figure cannot be directly compared to the unemployment totals at the Asile Clinique because at the Maudsley, the occupation of the person responsible for the unemployed woman or young person was listed [see Table 9 above].

Patient numbers at Bethlem and the Maudsley hospitals showed a marked female bias, with c.40% men and c.60% women.¹⁹⁴ This was typical of English institutions for the mentally ill at that time. In 1915, of the 137,188 cases of notified mental illness in England and Wales, 53.8% were women. This proportion remained stable until 1946.¹⁹⁵ As the BoC noted in 1934, female voluntary admissions were increasing faster than male. This was to be expected since “the man is generally the breadwinner of the family, and therefore is compelled by economic considerations to defer applying for treatment”.¹⁹⁶ Just 32% of British women in 1921 and 34% in 1931 were in paid employment.¹⁹⁷ Women comprised c.30% of the British labour force in 1921. Paid employment for women was concentrated in five sectors: personal services; commercial, financial and insurance occupations; clerical work; textiles and clothing.¹⁹⁸ There are no details regarding the gender split of occupations at Bethlem or the Maudsley during this period, but it was noted that at the Maudsley in 1925 that the new carpentry and upholstery workshops “greatly increased opportunities for the employment of suitable male patients”, while “both sexes of patient” had been engaged in gardening and clerical work.¹⁹⁹

¹⁹⁴ See Tables MH-1 and BR-1 in the Appendices.

¹⁹⁵ Andrews et al., *The History of Bethlem*, 657.

¹⁹⁶ Twenty-first Annual Report of the BoC, 1934, 2.

¹⁹⁷ Ian Gazeley, “Manual Work and Pay, 1900-70,” in *Work and Pay in 20th Century Britain*, ed. Nicholas Crafts, Ian Gazeley, and Andrew Newell (Oxford: Oxford University Press, 2007), 56.

¹⁹⁸ *Ibid.*, 59.

¹⁹⁹ MHR, 1925, 3.

Table 12: This table shows the sectors in which Seine patients were employed prior to admission during the period 1929-1938 (when different categories were used to describe employment types):

	1929 M	1929 W	1933 M	1933 W	1936 M	1936 W	1938 M	1938 W
Farmers/gardeners	20	6	33	9	47	9	60	9
Artists/musicians	-	4	-	16	-	-	-	-
Laundry workers	-	7	-	22	-	22	-	27
Bakers			11	-	33	-	31	-
Embroiderers	-	1	-	5	-	12	-	3
Traders	43	42	62	23	28	18	61	24
Beveridges – bosses	-	-	-	-				
Beveridges – workers	10	-	82	-				
Concièrges	-	21	-	41	13	56	13	42
Seamstresses	-	85=4%	-	107=4%	-	147=5%	-	135=4%
Cooks	-	71	-	46	-	59	-	57
Chauffeur (driver)					91	-	68	-
Domestic servants	33	96=4%	17	176=7%	38	217	17	212=7%
Typists			-	41	-	57	-	61
Religious/Clerical	1	-	-	-	-	-	-	3
Employees of commerce + admin	138 = 7%	117=5%	259=13%	124=5%	318=13%	158=5%	320=12%	177=6%
Students	-	2	-	6	8	9	14	6
Day labourers	126=7%	84=4%	396=19%	35=1.5%	353=15%	138=4%	352=13%	128=4%
Chambermaid	-	14	-	46	-	-	-	-
Florist	-	12	-	9	-	9	-	-
Waitress			-	20	-	19	-	20
Warden			4	-	15	-	-	-
Industry – bosses	-	-	-	-	-	-	-	-
Industry – workers	535=29%	-	376=18%	80=3%	568=23%	100=3%	528=20%	107=3%
Nurses			3	22	9	21	6	34
Primary school teachers	-	11	-	12	-	-	-	-
Lingerie	-	6	-	14	-	-	-	-
Market traders	-	3	-	-	-	-	-	-
Travelling salespeople	10	-	19	5	32	12	28	8
Milliner	-	3	-	10	-	14	-	24
Cleaner	-	124	-	62	-	-	-	-
Military	16	-	7	-	8	-	12	-
“Manutentionnaires”			-	18	-	-	-	-
Teachers			-	7	1	26	4	18
Liberal professions	32	-	87	3	77	15	41	20
Property owners	15		-	-	-	-	-	-
Upholsterers			-	1	-	-	-	-
“Garçons de commerce”					167	-	144	-
“Ouvriers d’art”					14	4	23	7
Without profession	886 (48%)	1,471 (66%)	678 (33%)	1,432 (60%)	517 (21%)	1,936 (63%)	842 (32%)	2,081 (65%)
TOTAL	1,855	2,244	2,034	2,395	2,424	3,056	2,637	3,208

In France, numerous laws passed between 1874 and 1919 were aimed at restricting a woman's right to work in an attempt to encourage women to remain at home and become mothers.²⁰⁰ The promotion of motherhood was explicit in the maternity laws of 1909-13 amid concerns regarding France's low birth-rate and high level of infant mortality.²⁰¹ That said, women comprised nearly 40% of the French labour force in 1921. Even though this figure decreased to 36% in 1936, the female proportion of the workforce was higher in France than in Britain, where, paradoxically, there was less emphasis on women's role as mothers.²⁰² At the Asile Clinique, work for female patients was associated with their domestic roles as wives and mothers, such as mending and making clothes, cleaning, ironing, working in the laundry and kitchen [see Table 13 below].

Table 13: This table shows the different categories of employment for patients, and the numbers of patients employed within each category, at the Asile Clinique during the period 1937-40:

Category /place of Work	1937	1939	1940
Administrative	9	10	10
Office Work (men)	8	7	7
Office Work (women)	7	6	6
Library – patients	2	2	2
Library – medical	3	3	2
Admissions Service	7	9	8
Shoemaking Workshop	2	4	3
Guard Room (men)	1	3	3
Guard Room (women)	1	1	1
Tennis courts	1	1	1
Pharmacy	2	3	3
Plumbing Workshop	1	2	2
Decorating Workshop	2	2	2
Lecture Theatre	1	1	1
Transport	1	1	1
Cloakroom	2	2	2
Gardens	13	17	12
Mechanics' Workshop	1	1	1
Construction/builders' yard	3	4	3
Electricity Workshop	3	4	3
Tailoring Workshop (men)	4	5	6
Tailoring Workshop (women)	1	1	-
Locksmiths' Workshop	4	5	4
Carpentry Workshop	3	5	3

²⁰⁰ Elinor Accampo, Rachel Fuchs, and Mary Lynn Stewart, *Gender and the Politics of Social Reform in France, 1870-1914* (Baltimore and London: Johns Hopkins University Press, 1995), 9.

²⁰¹ Ibid.

²⁰² Susan Pedersen, *Family, Dependence, and the Origins of the Welfare State: Britain and France 1914-1945* (Cambridge: Cambridge University Press, 1993), 124-5.

Heating Workshop	2	2	2
Laundry (men)	16	24	21
Laundry (women)	2	2	2
Lingerie (men)	4	4	3
Lingerie (women)	1	1	1
Wine Cellar	3	3	2
Surgery	5	5	6
Road Mending	9	11	10
Kitchen (men)	9	14	10
Kitchen (women)	13	12	14
Mending/sewing	5	5	5
Ironing Workshop	6	7	7
Couture A Workshop	16	20	19
Couture B Workshop	23	28	28
Housework	56	58	50
Floor Scrubbers	56	58	50
Hairdresser	-	-	1
TOTALS	308	349	320

5.6.2 The Mental and Physical Condition of Patients

All four metropolitan hospitals discussed in this chapter specialised in acute cases. This was important from the point of view of patient work because before World War I patient work had been considered unsuitable for acute patients. Work was for chronic, incurable and convalescent patients. Bed-rest (*l'alitement*), sometimes for up to several weeks, was the main treatment for acute patients advocated by the revered CMO of the Ste Anne's Admissions Service, Valentin Magnan.²⁰³ Bed-rest for acute patients was also promoted by the BoC in England. The Boc maintained that bed-rest in the open-air constituted "a material aid to healthy metabolism, a powerful tranquilizer and a valuable corrective in cases of insomnia".²⁰⁴ New theories concerning patient occupation, discussed in chapter four, challenged the view that prolonged, complete rest was the most effective treatment for acute cases. Hermann Simon believed that patients at the very beginning of their illness could benefit from work, and in the US, Adolf Meyer prescribed simple arts and crafts for patients whilst still confined to bed. The Swiss psychiatrist Eugen Bleuler maintained that

²⁰³ Henri Rousselle, Rapport au nom de la 3e Commission sur les Budgets et Comptes de l'Asile Clinique, CGS, 1903; 5-7; ADP/D.10K3/15/38; Rousselle, Rapport, 1911; 4-6, ADP/D.10K3/21/42.

²⁰⁴ Eleventh Annual Report of the BoC, 1924, 23.

“every mental institution” should be able “to offer every patient some kind of work at all times”.²⁰⁵

The MS of the Maudsley embraced this new approach to occupation for acute patients. While he believed that bed-rest for “a considerable time after admission” was necessary for most acute cases, he recognised “the need of industries for those confined to bed, or ... to the wards”.²⁰⁶ Once patients were up, all were given some sort of work, either “household duties”, needlework, clerical work, gardening, upholstery or carpentry.²⁰⁷ Patients made bed tables, letter boxes for the wards, wardrobe lockers, washstands and mortuary trolleys, among other items, and maintained the hospital furniture.²⁰⁸ An occupations officer was employed in 1925 who taught “a large variety of handicrafts” including rug- and basket-making, leather, pewter, embroidery and raffia work to patients on the wards.²⁰⁹ The results were very successful and had an “undoubted beneficial effect”.²¹⁰ Patients were less inclined to “morbid preoccupation with their troubles” and less vulnerable to “boredom and deterioration”.²¹¹ Mapother was aware that because the average length of stay in hospital for Maudsley patients was short (usually around three months), occupational therapy had to be organised differently to that provided in a mental hospital or orthopaedic hospital where patients remained for long periods. The arts and crafts activities taught by the OT department had to be relatively simple, so the techniques could be grasped quickly to produce rapid but pleasing results.²¹²

All Maudsley patients were at the acute stage of their illness, but their symptoms were not certifiable at the time of admission.²¹³ The fact that patients’ symptoms were relatively mild, and their prognosis generally good (affirmed by the high rate of cure shown in Table MH-3), suggests that they were likely to be capable of work or OT as soon as they had undergone the initial rest period recommended by Mapother. The records do not indicate

²⁰⁵ Richard Warner, *Recovery from Schizophrenia: Psychiatry and Political Economy*, Third ed. (Philadelphia: Routledge and Kegan Paul, 2004), 16.

²⁰⁶ MHR 1924, 9.

²⁰⁷ Ibid., 8-9.

²⁰⁸ MHR 1926, 5.

²⁰⁹ MHR 1925, 3.

²¹⁰ Ibid., 3.

²¹¹ Ibid., 3, 26.

²¹² MHR 1926, 5.

²¹³ MHR 1924, 12.

the numbers of patients occupied at the Maudsley, but Mapother suggests that everyone who was “up” was given work and those in bed or on the wards were occupied with OT except at the very beginning of their stay. At Bethlem, on the other hand, a significant (if declining)²¹⁴ proportion of patients were certified, indicating that their symptoms were more severe. Most patients, on admission to Bethlem, were sedated, often for several months.²¹⁵ It is reasonable to conclude that acute patients were not prescribed work. The numbers of patients recorded as “usefully employed” by the BoC’s inspectors between 1920 and 1928 suggest a consistent figure of around 65 patients (or c.30% of residents) during this period; these patients were most likely to be convalescent.²¹⁶ When OT was introduced in 1932, it was initially only provided in the OT workroom, suggesting that patients had to have recovered sufficiently to leave the wards. It was only two years’ later that OT was provided to patients who were confined to the wards.²¹⁷

At the Asile Clinique, there is no evidence that patients at the acute stage of their illness were given any form of occupation. Bed-rest continued to be the preferred treatment for acute cases at the Asile Clinique, as indicated in 1929 by CMO Dr Capgras’ observation of the difficulties of supervising patients undergoing bed-rest in the Asile Clinique’s overcrowded wards.²¹⁸ The bulk of the work around the hospital was performed by chronic patients specially drafted in for the purpose, and only a small percentage of patients from the treatment divisions worked. These were most likely to be convalescent patients, such as those in remission from GPI following malaria therapy or recovering alcoholics. Alcoholism and syphilis were rife in interwar Paris; alcoholics and those suffering from GPI featured prominently amongst male admissions to the Asile Clinique [See Tables 14, 16 and 17 below]. Alcoholism and GPI were also conditions ascribed to female admissions, but in less significant proportions prior to 1930 [see Tables 15, 18 and 19 below]. The Women’s First Section became a centre for malaria therapy in 1931, which accounts for a rise in the number of patients suffering from GPI after this date.²¹⁹

²¹⁴ In 1920, 75% of admissions were certified; this figure fell to c.50% in 1927 and to c.25% by 1939.

²¹⁵ Andrews et al., *The History of Bethlem*, 677.

²¹⁶ Employment records were not kept after 1928.

²¹⁷ BRH PS Report, 1934, 11. BMM/BAR-53.

²¹⁸ Dr Capgras, Rapport de la 1re section des hommes, Asile Clinique, 1929, 78. ADP/PER-566-5.

²¹⁹ Dr Leroy, Rapport de la 1re section des femmes, Asile Clinique, 1931, 77. ADP/PER-566-6.

Tables 14 and 15: These tables show the ascribed mental condition of patients admitted to the Asile Clinique Men's and Women's Division before the asylum's transformation to an acute service in 1927. The percentages of patients suffering from GPI and alcoholism are highlighted.

Table 14: Asile Clinique Men's Division:

	1919	1921	1922	1923	1924	1925
GPI	91 = 18%	61 = 21%	57 = 19%	69 = 20%	75 = 22%	94 = 22%
Alcoholism	69 = 14%	52 = 18%	75 = 30%	92 = 27%	106 = 32%	136 = 32%
Morphinism	2	5	1	2	1	4
Senile Dementia	32	12	8	15	19	13
Imbecility	9	1	3	4	3	2
Folie Simple	299	154	160	159	130	174
TOTALS	502	285	304	341	334	423

Table 15: Asile Clinique Women's Division:

	1919	1921	1922	1923	1924	1925	1926	1927
GPI	6 = 3%	15 = 9%	10 = 4%	12 = 6%	14 = 6%	15 = 7%	6 = 5%	8 = 5%
Alcoholism	15 = 8%	12 = 7%	23 = 9%	21 = 10%	38 = 16%	18 = 8%	11 = 9%	16 = 10%
Morphinism	0	0	0	0	0	0	0	0
Senile Dementia	18	17	27	25	18	19	11	6
Imbecility	0	0	0	0	0	0	0	0
Folie proprement dite	150	131	199	157	168	168	89	116
TOTALS	189	175	259	215	238	220	117	146

Table 16: This table shows the ascribed mental condition of patients admitted to the Men's First Section 1927-34. New categories of mental disorder were added in 1927 when the AC became an acute hospital. The percentages of patients suffering from GPI and alcoholism are highlighted.

	1927	1928	1929	1930	1931	1932	1933	1934
Mania	10	6	17		6	7	10	11
Melancholia	20	11	14		15	16	18	21
Acute delirium	20	5	9	24	2	2	4	1
Polymorphous delirium					2		2	1
Delusions of persecution					5	2	1	2
Imbecility/debility/mental imbalance	6	8	15	15	13	8	15	27
Degeneration	8	6	3		-			
GPI	33 = 22%	63 = 33%	93 = 34%	55	41 = 22%	17 = 9%	37 = 17%	33 = 13%
Epilepsy	6	-	3	2	6	8	6	5
Dementia – senile/organic	4	15	23	14	5	6	10	7
Mental confusion	4	14	5	21	18	22	11	18
Dementia praecox	13	18	11	10	2	8	6	6
Manic depressive psychosis				52				
Alcoholism	24 = 16%	43 = 23%	81 = 29%	62	54 = 29%	67 = 35%	84 = 39%	91 = 35%

Toxicomanie			2	2		1		
Encephalitis		1	-				-	
Periodic psychosis						10	5	7
Hallucinatory psychosis						5	4	3
Traumatic psychosis						2	-	
Paranoid dementia/psychosis						7	1	2
Weakened intellect					7	1	1	20
Other						-		4
TOTALS	148	190	275		189	190	217	259

Table 17: This table shows the ascribed mental condition of patients admitted to the Men's Second Section 1928-38. New categories of mental disorder were added in 1927, when the AC became an acute hospital, and in 1938. The percentages of patients suffering from GPI and alcoholism are highlighted. This table, and AC-MFS2 above, indicate that the incidence of GPI was decreasing during the 1930s while alcoholism remained a significant category.

	1928	1929	1930	1931	1932	1933	1934	1938
Mania	22	22	20	31	24	27	25	14
Melancholia	23	24	21	21	24	30	24	12
Delusions of persecution	28	31	29	31	23	29	19	8
Imbecility/debility	6	4	4	4	4	2	3	14
Degeneration								
GPI	40 = 14%	47 = 15%	38 = 13%	27 = 8%	14 = 6%	22 = 8%	12 = 5%	32 = 7%
Epilepsy	15	7	11	10	5	3	2	4
Dementia – senile/organic	18	17	27	20	12	25	16	35
Mental confusion				12	14	8	10	30
Dementia praecox	20	18	22	14	14	17	12	6
Alcoholism	88 = 32%	136 = 43%	117 = 39%	130 = 41%	99 = 41%	104 = 37%	3 = 1.3%	212 = 47%
Encephalitis	3			1				
Acute delirium	8	6	8	8	2	3	4	2
Instinctive perversions	5	4	1	1		3	2	
Mental imbalance				4	1			11
Delirium (non-acute)					5	5		14
Paralytic dementia								3
Dementia – arterial								10
Periodic psychosis								9
Weakening of the brain								3
Hallucinatory psychosis								6
Backwardness								2
Schizophrenia								16
Other				6	1	6		5
TOTALS	276	316	298	320	242	284	236	448

Table 18: This table shows the ascribed mental condition of patients admitted to the Asile Clinique Women's First Section. The list of conditions was widened in 1929; the category "folie proprement dite", or "proper madness", was dropped. The Women's First Section became a centre for malaria therapy in 1931, henceforth the majority of female GPI sufferers arriving at the Ste Anne's Admissions Service were sent to the Asile Clinique Women's First Section. This explains the significant rise in the number of GPI admissions in 1931.

	1928	1929	1931	1932	1933	1934	1938
GPI	11 = 11%	19 = 18%	113 = 67%	110 = 80%	142 = 83%	101 = 46%	102 = 40%
Alcoholism	10 = 10%	21 = 20%	14 = 8%	9 = 7%	6 = 3%	18 = 8%	20 = 8%
Senile Dementia	8	3	1	-	4	8	15
"Proper madness"	67	-	-	-	-	-	-
Dementia praecox		11	3	3		-	
Delusions of persecution		16	3				
Mania		9	5	3			
Mental debility		12	6	1	4	12	8
Imbecility		3					
Melancholia		8	8	3		4	10
Paranoid psychosis		1	1				
Hallucinatory psychosis			11	8	3		
Manic-depressive psychosis					12	23	10
Puerperal psychosis						7	14
Organic dementia		1	-				
Toxicomanie		1	1				
Encephalitis		1	-		1		
Erotomania		1	-				
Acute delirium						6	15
Chronic delirium						25	10
Mental confusion						6	28
Hebephreno- catatonic syndromes						8	11
Mental imbalance							10
Other				1		3	
TOTALS	96	107	166	138	172	221	253

Table 19: This table shows the ascribed mental condition of admissions to the Asile Clinique Women's Second Section. The admission of GPI sufferers decreased (most were sent to the First Section) whilst that of alcoholics remained fairly constant. The main conditions ascribed to Second Section patients were melancholy and senile dementia.

	1928	1929	1930	1931	1932	1933	1934	1938
Idiocy/imbecility/ mental debility	18		5	12	13	10 + 13	16	30
Mental imbalance							11	32
Mania	29	34	25	34	23	26	25	31
Melancholy	45	33	51	38	42	36	43	35
Epilepsy	5		2	2	1	2	1	3
Degeneration	5	3	4	3	1	2		-
Alcoholism	23 = 9%	1	14 = 6%	21 = 8%	27 = 11%	36 = 17%	21 = 9%	24 = 7%
GPI	21 = 8%	12	10 = 4%	8 = 3%	2	2	8 = 4%	4
Senile Dementia	18	34	43	37	19	9	16	57

Dementia praecox	11	13	5	16	6	5	8	2
Organic dementia	5	9	3	4	2			7
Delusion of persecution	12		11	23	26	15	16	42
Confusion/acute delusion	19	25	28	40	30	25	30	49
Periodic psychosis	5	6	10	10	8	11	10	5
Puerperal psychosis	7	9	10	9	14	5	3	
Hallucinatory psychosis	28	9	22	20	20	15	11	
Hysteria	1	1		1	6	1		
Chorea				1	-	1	2	
Schizophrenia								10
Délire d'influence								13
Other			2	1	-		2	3
TOTALS	252	233	247	280	240	214	223	347

Alcoholism was a curable condition, as indicated by the fact that in 1933, alcoholics accounted for 70% of patients discharged cured.²²⁰ Work had long been recognised as an effective treatment for mental disorders associated with alcoholism; the patient workforce in 1901 comprised “almost exclusively alcoholics and chronics”.²²¹ In the past, work had not been considered suitable for patients suffering from GPI; they were too turbulent in the early stages of the disease, and likely to cause accidents, and too weak at the end.²²² But since the introduction of malaria therapy, which resulted in the recovery or partial recovery of some patients, many were able to work after receiving the treatment. Following its introduction in 1927, the prognosis for GPI patients improved. A convalescent quarter providing work for recovering GPI patients was established in the Women’s First Section, after its establishment as a centre for malaria therapy.

The poor physical health of patients admitted to the Asile Clinique may help to explain the small number of patient workers. As Dr Marchand of the Men’s First Section highlighted, many patients arrived at the Asile Clinique in a “very grave condition”.²²³ A healthier patient population at the Maudsley and Bethlem hospitals, in comparison to that of the Asile Clinique, is indicated by the relative patient death rates. These were much higher in Paris

²²⁰ Dr Marchand, Rapport de la 1re section des hommes, Asile Clinique, 1933, 75. ADP/PER-566-6.

²²¹ Henri Rousselle, Rapport au nom de la 3e Commission sur les budgets et comptes de l’Asile Clinique, CGS, 1901; 6. ADP/D.10K3/14/52.

²²² M. Navarre, Rapport Général, CGS, 1908, 6. ADP/D.10K3/18/35.

²²³ Dr Marchand, Rapport de la 1re section des hommes, Asile Clinique, 1936, 82. ADP/PER-566-6.

than London and a high percentage of the deaths at the Asile Clinique occurred within the first month of arrival, as indicated by the tables below.

Tables 20 and 21: These tables show patient deaths at the Asile Clinique, 1919-38, expressed numerically and as a percentage of the total numbers of patients treated each year. The lowest rate of death was 4.3% (in the Men's First Section in 1927) and the highest 33% (in the Women's First Section in 1929).

Table 20: Asile Clinique Men's and Women's Divisions 1919-25 (no figures for 1926):

	1919	1921	1922	1923	1924	1925
Total treated: Men's Division	768	665	709	735	735	827
No. deaths	175	99	81	106	103	101
% deaths	23%	15%	11%	14%	14%	12%
Total treated: Women's Division	550	557	672	558	610	585
No. deaths	40	42	69	53	55	60
% deaths	7%	7.5%	10%	9.5%	9%	10%

Table 21: Asile Clinique Men's and Women's First and Second Sections 1927-38:

	1927	1928	1929	1930	1931	1932
Total treated: Men's 1 st Section	484	353	493	477	410	410
No. deaths	21	26	77	44	36	23
% deaths	4.3%	7.4%	15.6%	9.2%	8.8%	5.6%
Total treated: Men's 2 nd Section	225	456	533	541	564	487
No. deaths	33	39	64	58	49	35
% deaths	15%	8.5%	12%	11%	9%	7%
Total treated: Women's 1 st Section	464	248	284	?	344	313
No. deaths	24	11	95	?	20	21
% deaths	5%	4.4%	33%	?	6%	7%
Total treated: Women's 2 nd Section	405	400	474	425	449	418
No. deaths	33	38	55	59	77	50
% deaths	8%	9.5%	12%	14%	17%	12%

	1933	1934	1935	1936	1937	1938
Total treated: Men's 1 st Section	432	478	473	442	426	608
No. deaths	42	34	42	55	57	60
% deaths	10%	7%	9%	12%	13%	10%
Total treated: Men's 2 nd Section	536	498	470	441	?	714
No. deaths	44	27	35	43	?	81
% deaths	8%	5.4%	7.4%	9.8%	?	11%
Total treated: Women's 1 st Section	350	393	392	421	443	432
No. deaths	54	26	44	41	53	54
% deaths	15%	6.6%	11%	9.7%	12%	12.5%
Total treated: Women's 2 nd Section	389	410	389	417	?	526
No. deaths	23	27	26	41	?	86
% deaths	6%	6.5%	6.7%	10%	?	16%

Table 22: This table shows patient deaths at the Maudsley Hospital expressed as a percentage of the number of the total number of male and female patients treated at the Maudsley during the year. The highest rate of death was 8.1% of male patients treated in 1929, and the lowest rate of death was 0.5% of female patients treated in 1935.

Year	Total no. Men treated	No. male patient deaths	% male patient deaths	Total no. Women treated	No. female patient deaths	% female patient deaths
1924	255	9	3.5%	335	18	5.4%
1925	255	6	2.4%	433	14	3.2%
1926	241	4	1.7%	456	16	3.5%
1927	317	23	7.3%	480	21	4.4%
1928	362	21	5.8%	434	16	3.7%
1929	333	27	8.1%	414	12	2.9%
1930	341	11	3.2%	428	13	3%
1931	339	6	1.8%	457	18	3.9%
1932	376	15	4%	514	7	1.4%
1933	364	5	1.4%	556	12	2.2%
1934	394	9	2.3%	549	7	1.3%
1935	407	7	1.7%	553	3	0.5%

Table 23: This table shows patient deaths at the Bethlem Royal Hospital expressed as a percentage of the number of the total number of male and female patients treated at Bethlem during the year. The highest rate of death was 10.3% of male patients treated in 1933; the lowest rate was 2% of female patients in 1939 (other than in 1930 when patient numbers were depleted).

Year	Total no. male patients treated	No. male patient deaths	% male patient deaths	Total no. female patients treated	No. female patient deaths	% female patient deaths
1919	164	14	8.5%	286	6	2.1%
1920	195	14	7.2%	232	12	5.2%
1921	212	12	5.7%	299	8	2.7%
1922	189	19	10%	241	6	2.5%
1923	176	11	6.3%	232	11	4.7%
1924	190	8	4.2%	262	18	6.9%
1925	209	11	5.3%	286	10	4%
1926	221	10	4.5%	295	17	5.8%
1927	194	14	7.2%	262	14	5.3%
1928	192	19	9.9%	245	13	5.3%
1929	174	16	9.2%	242	13	5.4%
1930#	128	2	1.6%	171	4	2.3%
1931	133	13	9.8%	185	13	7%
1932	187	11	5.9%	256	13	5%
1933	184	19	10.3%	234	7	3%
1934	185	6	3.2%	256	8	3.1%
1935	175	6	3.4%	283	13	5%
1936	184	7	3.8%	273	15	5.5%
1937	173	11	6.4%	278	13	4.7%
1938	178	5	2.8%	275	8	2.9%
1939	288	8	2.8%	289	6	2%

Patient numbers were kept to a minimum due to the hospital's move to new premises

Table 24a-d, below, show the duration of patients' stay at the Asile Clinique prior to death between 1919 and 1938, where indicated. In almost all years, at least 50% of patients died within 12 months of admission. In the Women's Second Section, over 80% of patients died within 12 months of admission.

Table 24a: Asile Clinique Men's Division:

	1919	1921	1922	1923	1924	1925
Under 8 days	12	12	0	13	16	19
8 – 15 days	18	9	13	8	4	7
15 days – 1 month	18	10	4	11	12	11
1 – 3 months	36	11	2	13	14	10
3 – 6 months	31	8	8	10	8	5
6 months – 1 year	30	13	17	11	8	8
1 – 2 years	11	15	14	14	19	12
2 – 5 years	14	18	14	21	17	22
Over 5 years	5	3	9	5	5	7
TOTAL NO. DEATHS	175	99	81	106	103	101
% deaths within 12m	83%	63%	54%	66%	60%	59%

Table 24b: Asile Clinique Men's Second Section:

	1927	1928	1929	1930		1931	1932	1933	1934	1938
Under 5 days	7	7	19	10	Under 24 hrs	4	3	1	11	24
5 days – 1m	9	9	17	13	1–8 days	14	11	17	1	33
1m – 3m	3	6	4	6	8 days – 1m	6	4	11	6	5
3m – 1yr	4	7	5	17	1 – 2m	43	2	4	9	6
1 – 2 yrs	5	10	5	12	2 – 3m	3				5
Over 2 yrs	5	-	14	-	Over 3m	18	15	11		8
TOTALS	33	39	64	58		49	35	44	27	81
% deaths within 12m	70%	74%	70%	79%						

Table 24c: Asile Clinique Women's Division:

	1919	1921	1922	1923	1924	1925	1926	1927
Up to 1 month	1 = 2.5%	9 = 21%	27 = 39%	15 = 29%	27 = 49%	27 = 45%	14 = 37%	10 = 42%
1 – 3 months	8	3	17	9	9	15	4	2
3 – 6 months	10	1	9	3	3	6	1	3
6 m – 1 year	3	6	8	4	6	4	5	2
1 – 2 years	4	9	3	7	4	5	4	4
2 – 5 years	9	6	2	6	3	2	5	2
Over 5 years	5	8	2	5	3	1	5	1
TOTAL DEATHS	40	42	69	52	55	60	38	24
% deaths within 12m	55%	45%	61%	60%	82%	87%	63%	71%

Table 24d: Asile Clinique Women's Second Section:

	1931	1932	1933	1934	1938
0 – 3 months	47 = 61%	40 = 80%	12 = 52%	18 = 67%	75 = 87%
3 – 6 months	13	6	4	3	4
6 m – 1 year	12	3	3	2	3
1 – 2 years	3	1	2	2	2
2 or more years	2	-	2	2	2
TOTALS	77	50	23	27	86
% deaths within 12m	94%	98%	83%	93%	98%

The poorer physical health of Parisian patients, many of whom suffered from tuberculosis and other respiratory conditions, helps to explain the low percentage of patient workers. Another explanation may lie in the fact that the Asile Clinique, although specialising in acute cases, also accepted severe chronic cases requiring intensive nursing, as outlined in 1928 by

Dr Marie in his definition of acute and chronic cases.²²⁴ These patients included those suffering from senile dementia, imbecility, mental debility and idiocy. Dr Truelle complained in 1928 that there remained in the Men's Second Section "a stock of very old, chronic patients" whom he could not transfer either for family reasons or because the patients were too weak. These severe chronic cases were unlikely to be workers, and there is no evidence that they were given OT. Work at the Asile Clinique appeared to be restricted to the stronger chronic patients who were drafted in for the purpose and convalescent patients. The latter, after a short recovery period, were going to have to leave the asylum and live independently.

5.7 Work Outside the Asylum – Rehabilitation and Support

As well as fulfilling cost-saving and therapeutic functions, patient work also fulfilled a rehabilitative function. As discussed in chapter three, in England and France the late nineteenth-century emphasis on ensuring that patients were self-sufficient on leaving hospital began to decline during the early twentieth century. During the interwar period this process accelerated (earlier in England than France) as attitudes towards unemployment changed and welfare measures to support the jobless expanded. This raises the question of the relevance of patient work as a means of rehabilitation. Whilst welfare measures may have been in place to support those without work, governments were nonetheless intent on increasing levels of productivity, as indicated by the emphasis on "national efficiency", particularly in the immediate aftermath of World War I. Efforts to rehabilitate patients for the workplace were therefore important from a productivity perspective. In France, in particular, where there was a labour shortage following the death of so many working-age men during the war, coupled with a very low birth rate, capable workers were needed to enter the labour market. Work skills were also important from a medical perspective, since patients who left hospital without the prospect of employment or support were more likely to suffer a relapse of their mental symptoms as a result of anxiety and loss of self-esteem.²²⁵ Furthermore, in France, an ability to work was considered one of the criteria for discharge.²²⁶ Successful rehabilitation depended partly on whether the activities undertaken

²²⁴ Dr Marie, Rapport du Service de l'Admission, Asile Clinique, 1927, 49-50. ADP/PER-566-5.

²²⁵ See: Aubrey Lewis, "Neurosis and Unemployment," *The Lancet* no. 2 (1935): 297.

²²⁶ Guillemain, *Chronique De La Psychiatrie Ordinaire*, 45.

by patients in hospital prepared them for work in their local community, and partly on the availability of support from outside agencies.

5.8.1 Rehabilitation for the Labour Market

Despite the ongoing importance of rehabilitation, the evidence does not suggest that the work and occupation offered to patients in metropolitan hospitals prepared patients for the new developments taking place in the economies of Paris and London. Patient occupation continued to be based on institutional requirements in Paris, and on a blend of institutional requirements and arts and crafts in London. The emphasis in the metropolitan institutions was on curable patients, who would recover and need a means of supporting themselves after discharge. It is reasonable to assume that developing or maintaining the requisite skills for the contemporary labour market, particularly in the light of contemporary concerns regarding national efficiency and productivity, would be an important aspect of patient rehabilitation. However, the type of work performed within the Asile Clinique did not evolve to reflect developments in local employment during the interwar period, while the arts and crafts activities comprising OT at Bethlem and the Maudsley were not vocational. These occupations may have equipped patients with the skills required in traditional sectors of employment, such as tailoring or furniture-making, but they did not prepare patients for work in new industrial sectors, such as the automotive sector or electrical goods' manufacture. Furthermore, the occupations offered to female patients failed to reflect the increasingly diverse employment opportunities open to women after World War I.

While traditional industries persisted in the city centres, new industries mushroomed in the suburbs, many of which were based on modern management and production techniques, such as the assembly line. In Paris, for example, the traditional sectors of publishing, *haute couture* and jewellery remained in central Paris, while the suburbs became host to large-scale enterprises in new industrial sectors, such as automobiles (the Citroen plant was established in 1919) and chemicals.²²⁷ In London, too, major industrial growth took place in the suburbs (the Ford Motor Company arrived in Dagenham in 1931) but almost 37,000 factories involved in clothing, furniture, food and drink, printing and engineering remained

²²⁷ Colin Jones, *Paris, Biography of a City* (New York and London: Penguin, 2004), 407.

in London's old industrial centre.²²⁸ Industries deploying new technology showed the most spectacular growth in interwar London. Between 1925 and 1937 the numbers employed in the manufacture of electrical goods rose from 48,000 to 113,500, an increase of 138%.²²⁹ The other major growth area in both Paris and London was the service sector. In Paris, between 1906 and 1931, employment in banking and business grew by 52% and in administration and retail by 77%.²³⁰

The skills required by the new, rapidly expanding industries, such as automobile and electrical goods' manufacture, were not developed by the work offered at the Asile Clinique, the HRH, Bethlem or the Maudsley, or by the OT offered at the English hospitals. Patients still contributed to the work of running the hospital, helping with such tasks as growing and preparing food; maintenance of institutional buildings and grounds; mending, laundering and ironing clothes, bed-linen, towels and other items; making and repairing shoes; working in the workshops and cleaning the wards. The work was not orientated towards the local economy or to new working methods. Although the scientific management methods of Taylor and Bedaux were still in their infancy in the early 1920s, the factory and the assembly line - rather than the workshop - had become the new working environment for which patients left the asylum ill-prepared.²³¹

The activities comprising AOT (outlined in chapter four) were quite different to work on the factory floor in London's expanding industrial sectors. Instead of performing work for which little or no skill was required, patients were taught a craft and how to make aesthetically pleasing objects from scratch. The teaching of arts and crafts to patients inherent in AOT was influenced by the Arts and Crafts Movement, which encouraged the creation of hand-made goods in place of machine uniformity. Craftsmanship was considered to have a spiritually uplifting quality and to have a "regenerative power".²³² In other words, arts and crafts were perceived as an antidote to modern factory production methods. Elizabeth Casson, who founded the Dorset House School of OT in 1930, maintained that crafts

²²⁸ Stephen Inwood, *A History of London* (Basingstoke: Macmillan, 1998), 728.

²²⁹ *Ibid.*, 731.

²³⁰ Jones, *Paris, Biography of a City*, 407.

²³¹ Gerard Noiriel, *Workers in French Society in the 19th and 20th Centuries* (New York: Berg, 1989), 135-6. [See chapter 2:2:1 for discussion of the scientific management methods of Taylor and Bedaux]

²³² Rosalind Blakesley, *The Arts and Crafts Movement* (London and New York: Phaidon, 2006), 8.

activities were designed to “arouse curiosity and the desire to achieve”.²³³ The therapeutic benefits of OT were related to the pride taken in the patient’s work, the care and attention to detail invested, and the fact that the patient was responsible for the whole task, not just one tiny aspect of production. While OT developed concentration and self-esteem, it was not rehabilitative in an economic sense – except for the few Maudsley patients who managed to turn arts and crafts into a paying hobby or became occupational therapists themselves.²³⁴

One of the criticisms of OT and institutional work made by contemporary psychiatrists after World War II, as Vicky Long has highlighted, was that they failed to prepare patients for the modern workplace.²³⁵ This anomaly was addressed in the 1950s with the introduction of “industrial therapy” (IT) into English mental hospitals. The IT units incorporated industrial features such as factory lighting and seating, conveyor belts and time sheets. Work was supplied by local firms and involved simple tasks, such as folding cardboard boxes, for which patients were paid a low hourly rate.²³⁶ Whilst arguably less satisfying than OT, IT prepared patients more effectively for the type of work they would find outside the hospital. This “social readjustment” was important at a time when institutional care was gradually being replaced with care in the community.²³⁷

The categories of asylum workshops (namely plumbing, stone-masonry, carpentry, locksmithing, painting, mechanical work, laundry and ironing services, shoe-making, tailoring and needlework) at the Asile Clinique had not changed since 1900, with the exception of an electricity workshop added in 1924 [see Table AC-11 in the appendices]. The latter only employed two or three patients, and therefore did not permit the widespread acquisition of skills in this new growth area. Some of the occupations carried out in the traditional workshops mirrored the artisanal aspect of Paris’ dual economy. Patients leaving the Asile Clinique having worked in the tailoring, needlework, carpentry or shoe-making workshops might find work in these sectors as they were still growing in Paris, but they were

²³³ Elizabeth Casson, “Foreword,” in *The Story of Dorset House School of Occupational Therapy 1930-1986*, ed. Betty Collins (Oxford: unpublished, 1986), 1. OBU Special Collections: Dorset House.

²³⁴ MHR, 1927-31, 16.

²³⁵ Long, “Work Is Therapy?,” 336.

²³⁶ *Ibid.*, 339.

²³⁷ *Ibid.*, 336.

not showing the rapid growth of the new industries. Many, such as shoe-making, were switching to modern production methods not used in hospital workshops.

Market-gardening was not an activity associated with the Parisian economy, but this occupation made an important contribution to the asylum's supply of food. Physical work in the open air had been considered particularly beneficial for patients since the early nineteenth century.²³⁸ Farm work in particular, which gave patients the satisfying experience of growing their own food, had been recommended by Pinel in his *Traité* of 1800.²³⁹ The restricted nature of this activity at the Asile Clinique was due to the availability of land in a city-centre institution rather than a reflection of the limited scope for employment in market-gardening in Paris. The large numbers of patients employed in the laundry reflected the fact that a hospital of over 1,000 patients produced a significant amount of laundry, rather than size of the laundry sector outside the hospital. The workshops only occupied approximately 30% of the Asile Clinique's working patients. How the other patient workers were occupied was only indicated for the years 1937 and 1939 [see Table 13, pages 74-5]. Housework and cleaning accounted for the employment of 32% of male and 43% of female patient workers in 1937, and of 27% of male and 39% of female patient workers in 1939. In 1937, clerical work was allocated to 10% of male and 5% of female patient workers, while in 1939 these figures had decreased to 8% of males and 4% of females [see Table 13]. Hospital employment in clerical work was therefore contracting, whilst outside hospital it was expanding.

It can be concluded, therefore, that neither the work around the hospital nor OT directly prepared patients for work in the local economy. In France, the emphasis was on work to contribute to hospital maintenance, while in England, where psychiatrists placed a greater premium on the therapeutic properties of occupation, the emphasis was on OT. Whilst both work around the hospital and OT developed discipline and concentration, and some of the workshop activities promoted artisanal skills, patients did not leave hospital with experience of modern workplace methods. Their ability to cope with living and working in the busy cities of London and Paris depended to a large extent on the support provided for patients

²³⁸ Dausset, Rapport Général, 1918; 45.

²³⁹ Philippe Pinel, *Traité medico-psychologique sur l'aliénation mentale, ou la manie* (Paris: chez Richard, Calille et Ravier, 1800), 225-6.

after discharge. Without adequate support, many patients' symptoms would return, and they would end up back in hospital. The BoC in England emphasised the need for "after-care" for patients in 1928, observing that the transition from "the ordered and sheltered life of the hospital to the stress and competition of the work-a-day world is too sudden and too severe for the convalescent".²⁴⁰

5.7.2 Support Outside Hospital

Before World War I, support for convalescent patients tended to be restricted to charitable provision, such as that offered by Lady Almoners and the Mental After Care Association (MACA) in England and the Patronage Societies in France. Provision was patchy, particularly in France. French patients, however, had the benefit of leaving the asylum with a small sum of money, earned whilst in the asylum. After World War I, support for recently discharged patients gradually became more professionalised, with the provision of psychiatric social services and outpatient facilities.

5.7.2.1 Organisations providing assistance

The importance of supporting recently discharged patients had long been recognised in England and France, but support was provided by external organisations rather than by the hospital. In France, a few departments had a *Société de patronage des aliénés guéris*, including the Seine, that fulfilled a similar function to that of MACA in England.²⁴¹ The Parisian society was a charitable organisation, founded in 1886, subsidised by 8,000F per annum by the General Council of the Seine, that aimed to assist indigent patients who had recently left a public asylum or hospice. Its function, however, was described by the Council as "incomplete and insufficient".²⁴² It was agreed that more comprehensive support for discharged patients was required, to avoid their return to the asylum. Many patients failed to secure work and soon fell into poverty. Employers were often reluctant to employ ex-asylum patients, and families frequently rejected discharged relatives.²⁴³

²⁴⁰ Fifteenth Annual Report of the BoC, 1928, 6.

²⁴¹ Each French department was supposed to create its own patronage society, subsidised by the prefecture, but provision was patchy.

²⁴² Dausset, "Rapport Général," 1918, 41.

²⁴³ Ibid.

In England, the Mental After Care Association (MACA) had been founded in 1879 by Rev. Henry Hawkins, chaplain of the Colney Hatch Asylum, to provide an alternative to the workhouse for pauper patients discharged from asylums. MACA was a national organisation, but most of its services were concentrated in the south east. Former patients were assisted with lodging, money and clothing and helped to find suitable work. In the 1920s and 1930s, MACA provided cottage homes for convalescent patients, who stayed for a short period of between a fortnight and three months.²⁴⁴ The BoC applauded the work of MACA, but felt that the larger hospitals should do more themselves in respect of after care.²⁴⁵ Some English hospitals had a Lady Almoner,²⁴⁶ a voluntary role whose remit included after care and visiting patients' homes. When the Maudsley first opened, a Lady Almoner collected "useful and important knowledge" for the medical staff, supported patients whilst in hospital and helped them find work after discharge.²⁴⁷ Mapother reported that a "great deal of time and thought" went into "re-establishing former patients in normal life again" in relatively stress-free situations that were unlikely to cause a relapse of their symptoms.²⁴⁸ During 1925, 98 Maudsley patients were assisted by the Lady Almoner.²⁴⁹ In 1929, a psychiatric social worker (PSW) replaced the Lady Almoner, pre-empting the BoC's call for "well-trained social workers" to be attached to mental hospitals and clinics, as they were at US hospitals.²⁵⁰

5.7.2.2 Psychiatric Social Workers

The importance of the role of the psychiatric social worker (or PSW) to modern psychiatry had been recognised by American psychiatrists, notably Adolf Meyer, since the early twentieth century. By 1920, knowledge of a patient's social environment was considered vital to an understanding of individual behaviour and the PSW was regarded as an

²⁴⁴ The provision of interwar support for convalescent patients by MACA is discussed in: Stephen Soanes, "Rest and Restitution: Convalescence and the Public Mental Hospital in England, 1919-1939" (University of Warwick, 2011).

²⁴⁵ Ibid.

²⁴⁶ The emergence and role of hospital almoners, widely considered as the forerunners of modern-day hospital social workers, is discussed by Lynsey T. Cullen, "The First Lady Almoner: The Appointment, Position, and Findings of Miss Mary Stewart at the Royal Free Hospital, 1895-99," *Journal of the History of Medicine and Allied Sciences* 68, no. 4 (2012): 551-82.

²⁴⁷ MHR 1925, 8.

²⁴⁸ MHR 1926, 6.

²⁴⁹ MHR 1925, 8.

²⁵⁰ Eighteenth Annual Report of the BoC, 1931, 3.

indispensable partner to the psychiatrist, gathering information on patients' family and community environment.²⁵¹ Edward Mapother cited as one of the most important developments during the Maudsley's first five years of operation, the increasing co-operation between PSWs and the hospital.²⁵² The investigations into a patient's social situation made by a PSW and the PSW's ongoing support of discharged patients were seen by Mapother as an "indispensable condition of ... progress in tackling mental illness".²⁵³ "For modern institutional psychiatry" to function effectively, he maintained, the co-operation of specially trained PSWs was essential.²⁵⁴

In France, the services of a PSW were regarded as essential by Édouard Toulouse, who ensured that a social services unit was attached to the SLPM's outpatient facility, organised along similar lines to the anti-tuberculosis outpatient facilities.²⁵⁵ The PSW, directed by the doctor, acted as a liaison between the hospital and the patient's family, providing advice, ensuring that treatment guidelines were being followed, and researching information about the patient's circumstances that might aid the doctor treating a patient in an outpatient facility or in hospital.²⁵⁶ Mental crises, or relapses, were often caused by irregular life-styles, overwork, lack of work, domestic difficulties or the breakdown of family relations; the PSW could investigate these issues.²⁵⁷ PSWs also helped patients find work that was appropriate for their condition, and to identify suitable employers.²⁵⁸ To facilitate the "best use" of the individual, the social worker could call upon the Service of Professional Orientation (also part of the SLPM) which identified the most suitable (and unsuitable) types of work according to an individual's characteristics.²⁵⁹ For those who were unable to work, the PSW found alternative means of support, such as placement in a family colony, hospice or retirement home.²⁶⁰ Toulouse described the social assistants as "indispensable

²⁵¹ Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 250.

²⁵² MHR, 1927-31, 17.

²⁵³ Ibid.

²⁵⁴ MHR, 1932-5, 38.

²⁵⁵ Henri Rousselle, Rapport au nom de la 3e Commission sur le Service départemental de prophylaxie mental les services annexes, CGS, 1923; 9. ADP/D.10K3/34/73.

²⁵⁶ Ibid.

²⁵⁷ Ibid.

²⁵⁸ Ibid.

²⁵⁹ Ibid.

²⁶⁰ Ibid.

collaborators” from the doctors’ perspective and as “precious guides” and “advisors” from that of patients.²⁶¹

A PSW service was not provided outside Paris during the interwar period (despite its recommendation to all departmental Prefects by the Ministry of Health in 1937), emphasising the difference in approach between the SLPM, which was heavily influenced by the American model of psychiatric care and the mental hygiene movement, and the traditional “closed” services, which remained custodial institutions. Toulouse, along with most English and American psychiatrists, recognised the significance of social and psychological factors in the causation of mental disorder. This was also reflected in the importance attached to the establishment of outpatient facilities, a key aspect of the mental hygiene movement’s preventative agenda.

5.7.2.3 Outpatient Facilities

In France, outpatient services were extremely rare outside Paris. They were offered at Toulouse’s SLPM, where patients could receive a range of specialist treatments, including psychotherapy; hydrotherapy; electrotherapy; UV-ray treatment; physiotherapy; organotherapy; and the administration of vaccines and serums, without admission to hospital, or following discharge from the HRH or the Asile Clinique.²⁶² This enabled patients to carry on with their regular work outside the hospital or asylum. Patients receiving psychotherapy received advice on the type of work that might better suit their aptitudes and could be referred to the social service for placement advice.²⁶³ Between the opening of the service in 1922 and 1934, the number of consultations given annually at the outpatient department rose tenfold from 3,289 to 31,817 [see Table SLPM-PP1 in the Appendices].²⁶⁴ The success of the outpatient facilities at the SLPM prompted the Ministry of Health to encourage their provision nationwide in 1937.²⁶⁵

²⁶¹ Toulouse, Rapport sur le fonctionnement et le développement de l’hôpital Henri-Rousselle, CGS, 1926-27; 60. ADP/D.10K3/42/91 Annexe.

²⁶² Henry Grangier, Rapport au nom de la 3e Commission sur le SLPM et les services annexes, CGS, 1925; 6. ADP/D.10K3/38/79.

²⁶³ Toulouse, Rapport sur le Centre de Prophylaxie Mentale et l’Hôpital Henri-Rousselle, CGS, 1931; 63. ADP/D.10K3/47/86 Annexe.

²⁶⁴ René Fiquet, Rapport au nom de la 3e Commission sur le Centre de psychiatrie et de prophylaxie mentale Henri-Rousselle et les services annexes, CGS, 1934; 3. ADP/D.10K3/51/88.

²⁶⁵ Rucart, Circulaire, 13/10/1937.

The Maudsley Hospital also had an outpatient department, working in tandem with the main hospital, referring cases that warranted in-patient treatment, but also treating some patients for prolonged periods independently. This, too, enabled patients to continue with their normal lives and work. The main treatment provided was psychotherapy. Between 1923 and 1935, the number of new outpatients registered at the Maudsley increased three-fold, the total number treated four-fold and the number of attendances was multiplied by thirteen times.²⁶⁶ By 1935, facilities were described as “grossly inadequate”.²⁶⁷ A complete replacement and enlargement of the outpatient department, scheduled for 1931, was postponed by the economic crisis to 1936.²⁶⁸ These plans for expansion indicate the value of the outpatient service as a means of support for patients outside hospital.

5.7.2.4 The French “Pécule de Sortie” or “Nest-egg”

English patients who worked in the various hospital departments were not paid; they merely received additional food rations, such as an extra portion of bread and cheese, or cup of tea for their trouble.²⁶⁹ Unlike their English counterparts, French patients were paid a nominal daily wage, or *pécule*, which accumulated during their stay in the asylum and enabled them to leave with a small “nest-egg” or *pécule de sortie*, given to them on discharge. This principle was established by the law of 1857.²⁷⁰ A minimum amount was set by law for the leavers’ nest-egg; if the patient had not managed to earn this amount before departure, the full amount was made up by the asylum. Although HRH patients were not obliged to work, they were paid if they chose to work. So, discharged patients were not entirely without funds, but the money was quickly spent as the cost of living in Paris was high.

The daily rate paid to patients varied according to their gender and to the type of work performed [see Tables AC-11 in the Appendices]. Women were paid less than men. The level of the *pécule* paid to Asile Clinique patients was criticised by the Surveillance Commission in 1921, when the average daily payment amounted to 0.42F for men and 0.27F for women.²⁷¹

²⁶⁶ MHR 1932-5, 8.

²⁶⁷ Ibid.

²⁶⁸ Twenty-third Annual Report of the BoC, Appendix E, 1936, 490.

²⁶⁹ Bethlem Royal PS Report, 1916, 30.

²⁷⁰ Articles 154-163 referred to the payment of patients.

²⁷¹ Procès-Verbal de la Séance du 25/6/1921, Commission de Surveillance des Asiles Publiques d’Aliénés de la Seine, 110. ADP/D1X3-42/3.

At the Asile Clinique in 1926, “wages” varied from 0.28F per day for women working in the sewing workshop to 0.39F per day for men working in the tailors’ workshop and 0.59F per day for men working in the locksmiths’ workshop. Men working in the market gardens earned 0.49F per day and those in the carpentry workshop, 0.47F, while women in the ironing workshop earned 0.37F per day.²⁷² Calls by CMOs for an increase to the level of the *pécule* paid to patients in all the Seine asylums resulted in rates being doubled, with effect from 1/1/1927. The minimum rate of 0.20F was raised to 0.40F and a maximum rate of 2.50F was introduced for those patients delivering an exceptional service.²⁷³ The patient assisting in the mechanics’ workshop in 1927 earned the maximum *pécule* of 2.50F per day.²⁷⁴ For the completely destitute there was also recourse to the *Fondation André*, a legacy that had been invested for the purpose of giving small lump sums to the poorest asylum patients on discharge. It was divided between the institutions of the Seine; 300F per annum was received by the Asile Clinique for distribution to its most needy patients.

5.7.2.5 Unofficial Support for Patients during the Depression

During the Great Depression and its aftermath, some patients chose to remain in the asylum as workers, despite being eligible for discharge. This was an “unofficial” means of support offered by CMOs who were aware of the unemployment situation outside the hospital. Equally, impoverished families were slow to collect their cured or improved relatives from the asylums, knowing that work was hard to find particularly for those bearing the stigma of internment.²⁷⁵ In 1935, for example, Dr Marchand of the Men’s First Section of the Asile Clinique, reported that an additional 10 patients could have been discharged that year, but had elected to remain at the Asile Clinique as workers and to continue their treatments as in-patients. These patients had been out of work when they were admitted and were unlikely to find work in the current economic climate.²⁷⁶ Marchand remarked the following year that previously unemployed patients who had been allowed to remain made excellent

²⁷² M.H. Béquet, Rapport au nom de la 3e Commission sur l’Asile Clinique, CGS, 1926; 8-13. ADP/D.10K3/40/105.

²⁷³ Procès-Verbal de la Séance du 6/11/1926, CdS des APAS, 239. ADP/D1X3-47.

²⁷⁴ F. Latour, Rapport au nom de la 6e Commission sur les comptes du directeur de l’Asile Clinique en 1927, CGS, 1928; 14. ADP/D.10K3/44/64.

²⁷⁵ M.E. Chausse, Rapport Général au nom de la 3e Commission sur le compte du Service des aliénés, CGS, 1932, 4. ADP/D.10K3/48/95.

²⁷⁶ Dr Marchand, Rapport de la 1re section des hommes, Asile Clinique, 1935; 90. ADP/PER-566-6.

workers.²⁷⁷ A similar situation emerged at the SLPM. Former patients of the HRH, who had been unable to find work after discharge, were employed in the hospital, performing such tasks as writing, locksmithing, plumbing, stone-masonry and painting.²⁷⁸ A sum of 43,196F was spent on remunerating these patients in 1936.²⁷⁹

5.7.2.6 In summary...

French patients, unlike their English counterparts, left the asylum with a small “nest-egg”, but in general support for patients outside hospital was more restricted in Paris than in London. The SLPM was the only institution of its type in the capital, and its social service and outpatient facility could not provide support for all those who needed it. The increasing levels of demand for the Maudsley’s outpatient facility were met by an expansion of the service and the opening of additional facilities in north London. This did not happen in Paris, where the SLPM remained the only provider. This was because Édouard Toulouse and his associates in Paris were unique in their support for the holistic, American model of psychiatric care. It was not until 1937 that the Health Minister, Marc Rucart, saw fit to recommend the services comprising the SLPM to other institutions in the capital and elsewhere. In England, on the other hand, support for the American model was more widespread and its principles had been recommended by the Macmillan Report of 1926. The English Mental Treatment Act of 1930, which provided for the widespread introduction of the outpatient system and the relaxation of the laws regarding admission, paved the way for greater fluidity between hospital and community. A means of preparing patients for life outside hospital was afforded by the hospital’s entertainments programme. The activities helped to establish links with the local community and to mitigate against the sense that patients were shut off from the rest of the world.

²⁷⁷ Dr Marchand, Rapport de la 1re section des hommes, Asile Clinique, 1936; 72. ADP/PER-566-6.

²⁷⁸ René Fiquet, Rapport au nom de la 3e Commission sur le Centre de psychiatrie et de prophylaxie mental Henri-Rousselle, CGS, 1936; 3. ADP/D.10K3/54/117.

²⁷⁹ Ibid.

5.8 Entertainment, Recreation and Leisure Activities

Like patient work, entertainments had been perceived as a useful way to divert the patient's attention away from their troubles and "morbid thoughts" since the days of moral therapy, practised in both French and English asylums in the early nineteenth century.²⁸⁰ The similarities between the events organised during the interwar period and those arranged by the moral therapists is striking. This suggests that, in the area of entertainment at least, little had changed either in France or England. In France, continuity with the past was encouraged by the law of 1857 (unchanged by amendments introduced in 1938) which stipulated that "distractions" and "intellectual occupations" should be provided for patients.²⁸¹ Not all psychiatrists agreed that distractions were important, as Paul Wahl noted, suggesting that ideas regarding treatment had moved on since the law was made.²⁸² Psychiatrists adopting an organicist stance (following the introduction of Morel's theory of hereditary degeneration in 1857) were unimpressed by the psychological methods favoured by the moral therapists. Wahl, however, believed that entertainments constituted a therapeutic agent of the "first order" provided they were intelligently applied.²⁸³ He maintained that recreation also provided relaxation for working patients; it broke up the monotony of asylum life; and gave some comfort to those obliged to spend long periods away from their home and families.²⁸⁴ In France, Édouard Toulouse described "*distractions*" as an essential element of treatment, complaining in 1913 and again in 1918 that their provision in Seine asylums was insufficient.²⁸⁵ At the HRH, Toulouse organised visits from local artists to give art lessons, free of charge, to patients, which he considered were curative.²⁸⁶ While patients at the Asile Clinique did not appear to benefit from such classes, some did produce works of art. This was collected by Dr Auguste Marie and exhibited at surrealist exhibitions during the interwar period.²⁸⁷

²⁸⁰ Entertainment in nineteenth-century British asylums is the subject of a forthcoming PhD thesis by Ute Oswald (Warwick University); see: <https://warwick.ac.uk/fac/arts/history/students/eportfolios/u1664073>

²⁸¹ Article 164, Circulaire du 20/03/1857, 77.

²⁸² Paul Wahl, "Distractions et travail intellectuel dans les Asile d'aliénés," *L'Aliéniste français* 1(1935):135-40.

²⁸³ *Ibid.*, 138.

²⁸⁴ *Ibid.*

²⁸⁵ Toulouse, Rapport de la division des femmes, 1re section, Asile de Villejuif, 1913, 184; ADP/PER-566-4; Dausset, Rapport Général, 1918, 27.

²⁸⁶ Henri Rousselle, Rapport au nom de la 3e Commission sur le Service départemental de prophylaxie mentale et les service annexes, CGS, 1923, 6-7. ADP/D.10K3/34/87.

²⁸⁷ See: Gérard Audinet, *La Folie En Tête: Aux Racines De L'art Brut* (Paris: Paris Musées, 2017).

Although Bethlem, the Maudsley, the HRH and Ste Anne's focused on acute patients who were not destined to remain in hospital for prolonged periods, all the hospitals provided an entertainments programme. Bethlem's entertainments were the most lavish, reflecting the hospital's registered status, more generous budget and middle-class clientele. That said, the type of activities organised in each of the hospitals, despite their differences in size and facilities, were similar. Concerts, dances, theatrical performances, cinema showings,²⁸⁸ Christmas celebrations, walks, and opportunities to play sport and other games featured in all the institutional programmes. The frequency of events varied between institutions, however, with Bethlem providing some form of entertainment for patients every day, and the Asile Clinique perhaps once a month. All the institutions had a library for patients, of varying degrees of sophistication, and all provided wirelasses in at least some parts of the hospital. The Asile Clinique, for example, provided two wireless radios for patient use in 1932.²⁸⁹ Singing and dancing classes were a popular feature at the Maudsley, while Swedish drill was introduced at Bethlem in 1923.²⁹⁰ Bethlem was the only hospital with its own magazine, entitled *Under the Dome* until the hospital's move to Monk's Orchard, when it became known as *Orchard Leaves*.²⁹¹ At the Asile Clinique, patients were treated to visits from the stars of Parisian music-hall and theatre.²⁹² The HRH boasted a piano and gramophone for patient use.²⁹³

Patients at the Asile Clinique were encouraged to receive visits from family and friends, which was believed to improve patients' social interactions as well as maintain links with home. Ste Anne's central location facilitated such visits, which took place for two hours on Thursdays and Sundays.²⁹⁴ Visitor numbers reached record levels in 1929, which was thought to be linked to the Asile Clinique's specialisation in acute cases, which meant that families were more involved.²⁹⁵ Visitors were not such a priority for the Maudsley or the

²⁸⁸ All the institutions faced a similar dilemma when "talkie" films were developed; whether to invest in the new equipment or risk the gradual disappearance of silent films from circulation.

²⁸⁹ Rapport Moral de l'Asile Clinique, 1932, 9. ADP/3719W-68.

²⁹⁰ BRH PS Report 1923, 17.

²⁹¹ BRH PS Report 1935, 15.

²⁹² Rapport Moral de l'Asile Clinique 1932, 9. ADP/3719W-68.

²⁹³ Henri Rousselle, Rapport au nom de la 3e Commission sur le Service départemental de prophylaxie mentale et les services annexes, CGS, 1923, 6. ADP/D.10K3/34/87.

²⁹⁴ J. Romazzotti, Rapport au nom de la 6e Commission sur les comptes du directeur de l'Asile Clinique en 1936, CGS, 1937; 2. ADP/D.10K3/56/81.

²⁹⁵ F. Latour, Rapport au nom de la 6e Commission sur les comptes du directeur de l'Asile Clinique en 1929, CGS, 1930; 13. ADP/D.10K3/46/76.

SLPM Hospital because these were “open” institutions and patients could choose to visit their families, or go into town to meet friends, a freedom denied patients at the closed asylum of the Asile Clinique.

5.9 Conclusion

The new methods of occupational therapy were not adopted at the Asile Clinique in France. The very low proportion of patient workers from amongst the treatment divisions suggest that work was only prescribed to convalescent patients and not to those at the early, acute stage of their illness. This is indicative of the CMO’s ongoing organicist stance and a lack of support for psychological methods of treatment, despite their tentative introduction at the Faculty Clinic and their widespread use at the HRH. There is little evidence concerning occupation for HRH and Faculty Clinic patients, apart from Toulouse’s remark that patients should keep themselves busy and an indication that some patients were being paid for work around the hospital. It can be assumed, given Toulouse’s psychobiological stance, that early-stage, acute patients were given occupation. This division between the approaches taken by the Asile Clinique (a “closed” asylum, even though it specialised in acute cases) and the Faculty Clinic and the HRH (both run as “open” hospitals) was highlighted by Aubrey Lewis when he visited Paris in 1937.

At the Asile Clinique, the importance of patient work to the hospital’s budget was emphasised by the drafting in of a team of chronic patients to perform the work around the institution. This was far more cost-effective than paying employees to carry out the work. This use of a separate team of chronic workers indicates not only the reliance on patient work as a means of off-setting costs, but also the view that the work could not be performed by patients at the acute stage of their illness, something that Hermann Simon (who devised the system of MAT) contested. The cost-savings made by the existing system of patient work was prioritised by the AD, with whom CMOs had to share responsibility for running the hospital, while the notion that work could not be performed by acute patients was a medical decision. This can be explained by the CMOs’ organicist perspective; the legacy of former Asile Clinique CMO, Valentin Magnan (also an organicist), who advocated prolonged bedrest for acute patients; poor nursing standards; the severity of patients’

mental conditions and poor physical health; and overcrowding and a lack of resources. The CMOs' preference for biological treatments was linked to their anxiety to demonstrate psychiatry's scientific credentials and to establish the profession as an independent discipline.

In England, on the other hand, new approaches to occupation were adopted at both the metropolitan hospitals, albeit belatedly at Bethlem. At the Maudsley, acute patients were occupied with simple arts and crafts whilst still in bed, and as soon as they were out of bed, they were given work around the hospital or more complex arts and crafts in the OT workroom. Mapother, MS of the Maudsley, took a psychobiological view of mental disorder that took account of a patient's psychological and physiological condition, and found psychological methods of treatment, including OT, effective. In fact, these were preferred over some of the more "heroic" biological treatments introduced during the 1930s, regarded with suspicion by Mapother as their effectiveness had not been proven. At Bethlem, the PS's organicist stance of the early interwar period led to the late adoption of OT at Bethlem. Patient work, for those whom it was appropriate from a class perspective, was restricted to convalescent patients.

Whilst patients made things for the hospital or for sale at the hospital canteen, or annual sale of work, there was no reliance on the contribution made by patient labour to English hospital budgets. This followed an encouragement by the BoC for mental hospitals to focus on the benefits of occupational treatment to the patient rather than to the hospital. The arts and crafts activities that comprised OT in England were designed to stimulate patients' interest and creativity and to boost their self-esteem, rather than to subsidise hospital running costs. OT was not vocational, and nor was there any deliberate attempt to orientate the work carried out around the hospital towards the types of employment available in London. A failure to prepare patients for local labour market opportunities was common to both the Parisian and London hospitals. However, both the Maudsley and the HRH offered support to patients after discharge, via social services and outpatient departments which enabled patients to receive treatment whilst living at home and working at their regular jobs. In England, outpatient facilities were also provided in several locations outside London, including Oxford, but this was extremely rare in provincial France.

Chapter 6:

Provincial Institutions in France and England

6.1 Introduction

Unlike the metropolitan institutions studied in the previous chapter, the clientele of the Littlemore Hospital in Oxford, England and the Asile de la Sarthe (ADLS) in Le Mans, France, was mixed. Patients suffered from both acute, curable and incurable conditions. Incurable patients far outnumbered the acute patients since the former remained in the institutions for long periods (often for life). This discrepancy between the patient profiles of metropolitan and provincial institutions is reflected by the percentages of patients discharged “cured” or “relieved”, which were much lower in provincial institutions, as is illustrated by Tables 25a-g, below. In England, following the passage of the Mental Treatment Act of 1930, the Littlemore began to admit an increasing number of early-stage, acute cases on a voluntary basis.

The proportions of acute, chronic and incurable patients within an institution had important implications for patient work, since before World War I, patient work had only been considered suitable for chronic, incurable and convalescent patients. Although new theories regarding the occupation of acute patients had emerged, these were not widely known in England or France until the 1920s. In the immediate post-war period, then, patient work in both French and English asylums remained restricted to chronic, incurable and convalescent patients. Because there were so many chronic and incurable patients, the workforces of provincial institutions were much larger than those of the metropolitan institutions where the majority of cases were acute. OT, as a treatment for acute cases, was less relevant for provincial institutions because the numbers of acute patients were relatively small, although as indicated above, at the Littlemore, the numbers of acute patients increased after 1930. However, as well as being beneficial for acute patients, OT was also useful for drawing out all patients, including the chronically ill, who had not hitherto been receptive to occupation, as the BoC highlighted in 1933.¹

¹ BoC *Memorandum*, 20-1.

Tables 25a-g: The following tables show the annual rates of discharge as a result of recovery or improvement, expressed as a percentage of the total numbers of patients treated, and of the numbers of men and women treated.

Table 25a: Asile Clinique – Men’s and Women’s Divisions, before transformation of the Service in 1927 (no figures for 1920, and only for the Women’s Division in 1926)

Year	Total no. treated during year (M:F)	Total no. patients discharged as recovered or relieved (M:F)	% discharged as a % of total treated (M:F)
1919	1,318 (768:550)	348 (220:128)	26% (29%: 23%)
1921	1,222 (665:557)	303 (161:142)	25% (24%: 25%)
1922	1,381 (709:672)	494 (234:260)	36% (33%: 39%)
1923	1,293 (735:558)	362 (228:134)	28% (31%: 24%)
1924	1,345 (735:610)	418 (228:190)	31% (31%: 31%)
1925	1,412 (827:585)	487 (324:163)	34% (39%: 28%)
1926	?,??? (??? : 479)	??? (??? : 123)	??? (???%: 26%)

Table 25b: Asile Clinique – Men’s and Women’s First Sections, after transformation of the Service in 1927 (no figures for 1939 and only for the Men’s First Division in 1930)

Year	Total no. treated during year (M:F)	Total no. patients discharged as recovered or relieved (M:F)	% discharged as a % of total treated (M:F)
1927	760 (296: 464)	400 (112: 288)	53% (38%: 62%)
1928	601 (353: 248)	169 (109: 60)	28% (31%: 24%)
1929	777 (493: 284)	291 (196:95)	37% (40%: 33%)
1930	??? (477: ???)	??? (212: ???)	??? (44%: ???%)
1931	754 (410: 344)	303 (154: 149)	40% (38%: 43%)
1932	723 (410: 313)	285 (171: 114)	39% (42%: 36%)
1933	782 (432: 350)	295 (171: 124)	38% (40%: 35%)
1934	871 (478: 393)	407 (219: 188)	47% (46%: 48%)
1935	865 (473: 392)	380 (210: 170)	44% (44%: 43%)
1936	863 (442: 421)	361 (164: 197)	42% (37%: 47%)
1937	869 (426: 443)	358 (147: 211)	41% (35%: 48%)
1938	1,040 (608: 432)	499 (302: 197)	48% (50%: 46%)

Table 25c: Asile Clinique – Men’s and Women’s Second Sections, after transformation of the Service in 1927

Year	Total no. treated during year (M:F)	Total no. patients discharged as recovered or relieved (M:F)	% discharged as a % of total treated (M:F)
1927	??? (??? : 405)	??? (??? : 224)	??? (???%: 55%)
1928	856 (456: 400)	373 (183: 190)	44% (40%: 47%)
1929	1,007 (533: 474)	403 (226: 177)	40% (42%: 37%)
1930	966 (541: 425)	350 (239: 111)	36% (44%: 26%)
1931	1,013 (564: 449)	464 (270: 194)	46% (48%: 43%)
1932	905 (487:418)	392 (200:192)	43% (41%: 46%)
1933	925 (536: 389)	409 (230: 179)	44% (43%: 46%)

1934	908 (498: 410)	405 (203: 202)	45% (41%: 49%)
1935	859 (470:389)	367 (186: 181)	43% (39%: 46%)
1936	858 (441: 417)	342 (150: 192)	40% (34%: 46%)
1937	???	???	???
1938	1,240 (714: 526)	670 (404: 266)	54% (56%: 51%)

Table 25d: The Maudsley Hospital, London, England (no recovered/relieved figures were given for the years 1925-31, nor for 1936-39.

Year	Total no. treated during year (M: F)	Total no. patients discharged recovered or relieved (gender unknown)	% discharged recovered or relieved as a % of total treated
1924	590 (233:335)		48%
1932	890 (376:514)	365	41%
1933	920 (364:556)	382	42%
1934	943 (394:549)	419	44%
1935	960 (407:553)	411	43%

Table 25e: The Bethlem Royal Hospital, London, England:

Year	Total no. treated during year (M: F)	Total no. patients discharged recovered or relieved (gender unknown)	% discharged recovered or relieved as a % of total treated
1919	450 (164:286)	128 (44: 84)	28% (27%: 29%)
1920	487 (195:292)	173 (65: 108)	36% (33%: 37%)
1921	511 (212:299)	157 (61: 96)	31% (29%: 32%)
1922	430 (189:241)	107 (48: 59)	25% (25%: 24%)
1923	408 (176:232)	96 (37: 59)	24% (21%: 25%)
1924	452 (190:262)	124 (47: 77)	27% (25%: 29%)
1925	495 (209:286)	135 (60: 75)	27% (29%: 26%)
1926	516 (221:295)	144 (60: 84)	28% (27%: 28%)
1927	456 (194:262)	101 (38: 63)	22% (20%:24%)
1928	437 (192:245)	112 (55: 57)	26% (29%: 23%)
1929	416 (174:242)	108 (43: 65)	26% (25%: 27%)
1930	299 (128:171)	74 (30: 44)	25% (23%: 26%)
1931	318 (133:185)	41 (21: 20)	13% (16%: 11%)
1932	433 (187:256)	119 (58: 61)	27% (31%: 24%)
1933	418 (184:234)	111 (56: 55)	27% (30%: 24%)
1934	441 (185:256)	118 (49: 69)	27% (26%: 27%)
1935	458 (175:283)	121 (39: 82)	26% (22%: 29%)
1936	457 (184:273)	130 (104: 26)	28% (56%: 10%)
1937	451 (173:278)	127 (41: 86)	28% (24%: 31%)
1938	453 (178:275)	155 (52: 103)	34% (29%: 37%)
1939	477 (188:289)	164 (62: 102)	34% (33%: 35%)

Table 25f: The Asile de la Sarthe, Le Mans, France:

Year	Total no. treated during year (M:F)	Total no. patients discharged as recovered or relieved (M:F)	% discharged as a % of total treated (M:F)
1921	738 (258: 480)	51 (24: 27)	7% (9%: 6%)
1922	736 (255: 481)	46 (17: 29)	6% (7%: 6%)
1923	759 (262: 497)	40 (28: 22)	5% (10%: 4%)
1924	802 (280: 522)	53 (23: 30)	7% (8%: 6%)
1925	829 (316: 513)	56 (22: 34)	7% (7%: 7%)
1926	860 (333: 527)	42 (14: 28)	5% (4%: 5%)
1927	863 (331: 532)	49 (18: 31)	6% (5%: 6%)
1928	881 (338: 543)	39 (13: 26)	4% (4%: 5%)
1929	885 (336: 549)	29 (8: 22)	3% (2%: 4%)
1930	904 (343: 561)	42 (19: 23)	5% (5.5%: 4%)
1931	910 (340: 570)	29 (10: 19)	3% (3%: 3%)
1932	941 (354: 587)	31 (5: 26)	3.5% (1%: 4%)
1933	954 (380: 574)	28 (13: 15)	3% (3%: 3%)
1934	993 (411: 582)	34 (19:15)	4% (5%: 2.5%)
1935	1,008 (418: 590)	46 (25: 21)	4.5% (6%: 3.5%)
1936	1,002 (398: 604)	54 (23: 31)	5.5% (6%: 5%)
1937	1,041 (425: 616)	65 (27: 38)	6% (6%: 6%)
1938	1,044 (433: 611)	44 (14: 30)	4% (3%: 5%)
1939	1,130 (500: 630)	84 (47: 37)	7% (9%: 6%)

Table 25g: The Littlemore Hospital, Oxford, England:

Year	Total no. patients treated (M:F)	No. patients discharged recovered or relieved (M:F)	% discharged cured or improved (M:F)
1923	734 (327: 407)	78 (31: 47)	11% (9.5%: 11.5%)
1924	758 (328: 430)	94 (36: 58)	12% (11%: 13%)
1925	851 (328: 523)	90 (37: 53)	11% (11%: 10%)
1926	849 (299: 550)	69 (20: 49)	8% (7%: 9%)
1927	853 (311: 542)	62 (21: 41)	7% (7%: 7.5%)
1928	871 (322: 549)	64 (25: 39)	7% (8%: 7%)
1929	891 (343: 548)	84 (29: 55)	9% (8%: 10%)
1930	929 (348: 581)	67 (23: 44)	7% (7%: 7.5%)
1931*	917 (350: 567)	53 (18: 35)	6% (5%: 6%)
1932	962 (363: 599)	81 (36: 45)	8% (10%: 7.5%)
1933	1,022 (387: 635)	98 (39: 59)	10% (10%: 9%)
1934	998 (375: 623)	96 (36: 60)	10% (10%: 10%)
1935	1,012 (381: 631)	89 (43: 46)	9% (11%: 7%)
1936	1,060 (411: 649)	102 (46: 56)	10% (11%: 9%)
1937	1,090 (409: 681)	109 (44: 65)	10% (11%: 9.5%)
1938	1,091 (412: 679)	104 (37: 67)	10% (9%: 10%)
1939	1,121 (422: 699)	114 (45: 69)	10% (11%: 10%)

Admissions policies, and the resulting patient profile, clearly had an important impact on patient work and the adoption of new practices of OT. At the Littlemore, the greater post-war emphasis on treatment promoted by the BoC and the influx of acute cases after 1930, encouraged the adoption of new ways of occupying acute patients. The MS's preference for psychological methods of treatment; the Littlemore's well-trained nursing staff; support from junior medical staff; and the fact that the institution did not suffer from overcrowding, all facilitated the adoption of OT. So too did the BoC's insistence that mental hospitals should focus on the benefits of occupation to the patient rather than on the economic benefits to the institution. At the ADLS, on the other hand, the asylum finances were dependent on the contribution made by patient work. The CMOs were organicists who preferred biological over psychological methods of treatment for acute cases. Nursing standards were poor and overcrowding a persistent and serious problem. These were all disincentives to the introduction of OT. At the ADLS, there was no provision of OT and patient work remained restricted to chronic and convalescent patients. In neither of the provincial institutions did the work provided for patients reflect the changing nature of the local economies, but this was less crucial for the many patients who were destined to spend much of their lives in the institution, as many were, particularly at the ADLS. The physical location of the institutions did, however, influence the type of work available to patients.

6.2 The Institutions

6.2.1 Location

Neither the Littlemore nor the ADLS were truly rural institutions. Unlike colonies for the intellectually impaired and incurable patients, they were not located deep in the countryside, far from centres of population. Both institutions were situated in or near provincial towns that served the surrounding rural populations of the county of Oxfordshire and the department of La Sarthe as well as those of the towns of Oxford and Le Mans. The Littlemore Hospital opened in 1846 in fifteen acres of farmland just over three miles south of the centre of Oxford.² The site afforded ample opportunity for agricultural work.

² Originally known as the Oxfordshire Pauper Lunatic Asylum, it became the Ashurst Military Hospital from 1918 until 1922 when it was taken over by the armed forces after World War I. It was returned to civilian use in 1922 and renamed the Littlemore Hospital.

Similarly, the ADLS, completed in 1828, was situated two kilometres from Le Mans, close to cultivable land at the confluence of the rivers La Sarthe and L'Huisne.³ The arrival of the railway station in 1854, and the subsequent rapid growth of Le Mans, resulted in the surrounding of the asylum by the railway line, the rivers and inhabited areas.⁴ As patient numbers increased, the available land within the existing asylum boundaries was soon built upon to provide more accommodation. The reduction of cultivable land compromised opportunities for agricultural work, forcing the asylum to lease a small farm some distance from the main patient accommodation. The latter was deemed impractical and the farm was given up in 1903, so unlike at the Littlemore, the provision of farm work for patients (considered particularly beneficial) was limited.

As a university town, Oxford was well placed to provide the Littlemore with medical students. This was advantageous for the MS who had access to support staff and enabled him to pursue more labour-intensive treatment, such as psychotherapy, malaria therapy and OT. Le Mans lacked a university during the interwar period, which made the recruitment of interns very difficult for the CMO. It was impossible for one CMO without medical support to provide adequate treatment for 800-900 patients, even if relatively few of them suffered from acute conditions.

6.2.2 Admissions Policies

Specialising in acute cases was unique to the metropolitan institutions of the Asile Clinique and Henri Rousselle Hospital in France, and in England, prior to 1930, to the Maudsley and Bethlem hospitals. Other institutions in Paris and London, and those outside the capital cities, received both acute and chronic cases, according to the legislation of 1838/1857 in France and 1845/1890 in England. Long-stay chronic and incurable cases tended to accumulate in provincial institutions, leading to overcrowding as new cases were admitted. In England, separate institutions for the intellectually impaired were supposed to be provided by local authorities, according to the terms of the Mental Deficiency Act of 1913, thereby relieving some of the pressure on mental hospitals. This depended on local

³ Guillemain, *Chronique De La Psychiatrie Ordinaire*, 14.

⁴ Ibid.

provision, however, and facilities in Oxford were limited. At the Littlemore, overcrowding was avoided because many mild, acute cases (whose early-stage symptoms did not warrant certification) were treated at the outpatient facility established in 1918. Early treatment as an outpatient prevented symptoms from becoming sufficiently severe to warrant certification and admission to the mental hospital.

Patients with early-stage, mild symptoms that did not warrant certification but required hospital treatment as inpatients, could only be admitted to registered or private mental hospitals before 1930. After that date, uncertified, early-stage, acute cases could be admitted to public provincial mental hospitals such as the Littlemore. Medical Superintendents were encouraged to transfer their chronic patients to Public Assistance Institutions,⁵ to allow acute cases to have “first call” on mental hospital beds, where they would receive active treatment.⁶ At the Littlemore, the numbers of voluntary patients increased from seven (five men and two women) in 1931 to 91 (28 men and 63 women) in 1939 [see Table 26]. As the number of acute cases increased, the nature of occupation within the hospital changed, with more patients engaged in OT on the wards.

Table 26: Table to show the numbers of Voluntary Patients admitted to the Littlemore Hospital each year following the Mental Treatment Act 1930:

	1931 – M	1931 – W	1932 – M	1932 – W	1933 – M	1933 – W	1934 – M	1934 – W
Voluntary Admissions	5	2	9	16	14	14	16	18
Discharged	4	2	8	14	12	13	13	16
Regraded	-	-	1	1	-	1	-	1
Died	1	-	-	-	1	-	1	-
Remained	-	-	1	1	1	-	2	1
Total no. admissions	55	75	78	98	88	129	79	121
% of vol admissions	9%	3%	12%	16%	16%	11%	20%	15%

Table 26 continues overleaf for years 1935-9...

⁵ Public Assistance Institutions replaced Poor Law Institutions, formerly known as workhouses.

⁶ Nineteenth Annual Report of the BoC, 1931, 4.

	1935 – M	1935 – W	1936 – M	1936 – W	1937 – M	1937 – F	1938 – M	1938 - W	1939 - M	1939 – W
Voluntary Admissions	21	26	32	27	25	26	31	51	28	63
Discharged	11	15	19	18	19	16	17	34	14	43
Regraded	1	1	2	1	-	-	1	1	2	-
Died	2	2	1	2	1	3	1	3	1	4
Remained	7	8	10	6	5	7	12	13	11	16
Total no. admissions	82	121	110	122	88	137	83	130	89	141
% of vol admissions	26%	21%	29%	22%	28%	19%	37%	39%	31%	45%

In France, colonies for incurable patients from the Seine department were first established in 1892⁷ at the instigation of Dr Auguste Marie but this model of care had not been extended to provincial departments. Nor was there an equivalent in France to the English Mental Treatment Act of 1930. A revision to the law of 1838, according to which patients had to be certified to gain admission to public asylums, as they did in England before 1930, had been proposed in 1914, but World War I broke out before the law was changed.⁸ This meant that ADLS patients included the intellectually impaired and chronic cases, as well as acute cases. As a result, there was little patient movement, and conditions became very overcrowded. As indicated above, there was no additional land (and even less money) available to build new quarters. Overcrowding hindered the introduction not only of new methods of occupation, but of all attempts at reform.

6.3 Government Support for Reform

The French Health Minister, Marc Rucart, acknowledged in 1937 that measures to combat mental illness had not been pursued as vigorously as those taken to fight against other social scourges, such as tuberculosis.⁹ Rucart re-iterated the arguments put forward by the English authorities a decade earlier. He stressed the “therapeutic, economic and social importance” of early treatment and maintained that pauper mental patients, “easily

⁷ “*Colonies familiales*” for the Seine’s incurable patients were established at Dun-sur-Auron in 1892 and at Ainay-le-Château in 1897.

⁸ Henri Colin, “Mental Hygiene and Prophylaxis in France,” JMS Oct (1921):459.

⁹ Marc Rucart, Ministre de la Santé publique, Circulaire du 13/10/1937 relative à l’organisation de l’Assistance psychiatrique dans le cadre départemental, 34. https://www.ascodocpsy.org/wp-content/uploads/textes_officiels/Circulaire_13octobre1937.pdf (accessed 03/12/2017).

curable” at the start of their illness, became a danger to themselves and others if their condition was left untreated. By the time their condition had deteriorated to the point where the law intervened, they faced the prospect of long-term internment in an asylum, perhaps for life, for which there was a heavy cost to society, both in terms of the patients’ care and their lack of productivity.¹⁰

Rucart’s Circular proposed the reorganisation of care for the mentally ill, along the lines already established in Paris by the SLPM, with the provision of “open services” for the voluntary admission of those with mild symptoms, outpatient facilities, social services and assistance for “abnormal children”.¹¹ These proposals, which would have improved psychiatric service provision throughout the country, did not take immediate effect. The CMO of the ADLS regarded such a reorganisation of the service in Le Mans as desirable but an impossibility at the time, and in 1939, the war intervened.¹² Another Ministerial Circular, dated 5/02/1938, which modified the regulations set out in 1857, sought to re-orientate the care of patients in “closed” asylums, such as the ADLS, towards a focus on treatment rather than custodial care.¹³ Henceforth asylums were to be known as “psychiatric hospitals”¹⁴ to emphasise this new focus, although as one psychiatrist observed, the change was in name only.¹⁵ The timing of these proposed changes meant that for almost the entire interwar period, the system of admission remained unchanged, and French provincial asylums, including the ADLS, continued to be overcrowded and dominated by chronic cases.

6.4 Alienism or Psychiatry?

This lack of reform within provincial institutions led historians Postel and Quétel to observe that the further French asylums were from cities the more they remained locked into psychiatric conservatism. They point to a cleavage between the progressive developments in the area of mental hygiene taking place in Paris, under Toulouse’s influence (including the establishment of “open” services, outpatient clinics, social services and research facilities),

¹⁰ Ibid.

¹¹ Ibid., 35-6.

¹² Rapport du Médecin en Chef, ADLS, 1938, 12. ADS/1X965.

¹³ Marc Rucart, Ministre de la Santé publique, Circulaire du 5/02/1938, Règlement modèle du Service Intérieur des Hôpitaux psychiatriques, 39. https://www.ascodocpsy.org/wp-content/uploads/textes_officiels/Circulaire_5fevrier1938.pdf (accessed 03/12/2017).

¹⁴ The Asile Clinique became a “treatment hospital” in 1927, but only officially changed its name in 1938 to the Hôpital Psychiatrique de Ste Anne.

¹⁵ Von Bueltingsloewen, *L'hécatombe Des Fous*, 284.

and other institutions outside the metropolis that were effectively left behind.¹⁶ Their distance from the capital and the reformist agenda of Toulouse and his colleagues, together with their isolation from the rest of medicine, meant that psychiatrists in French provincial asylums tended to retain an organicist outlook, based on hereditary degeneration, and to continue to run their asylums on a custodial basis. This was true of the ADLS until 1930, but after that date the physicians appointed CMO, whilst still organicist in orientation, were more heavily influenced by neurology and more disposed towards active biological treatment of acute cases.

At the Littlemore Hospital in Oxford, the long-serving MS, Dr Thomas Saxty Good, had originally been drawn towards an organicist approach to mental disorder, like his French colleagues, but became interested in “newer, psychological methods” after exposure to war neuroses.¹⁷ During World War I, Good worked as a military psychiatrist alongside psychologist William McDougall, treating cases of shell-shock with psychotherapy and hypnosis.¹⁸ At the Littlemore, the BoC noted with approval that “all patients are studied both from the physiological and the psychogenic point of view”.¹⁹ Although Good did not employ an occupational therapist, all the nurses were expected to be skilled in a craft which they taught to patients. Whilst teaching their crafts, the nurses were able to spend time talking to patients and learn about their lives. The notes the nurses took as a result of these conversations, the standard of which impressed the BoC, provided valuable information for the doctors.²⁰ In 1933, the BoC praised the Littlemore for the attention paid to the study of the patient’s mental state. They noted that while “careful attention is directed to the physical factors, the psychological and sociological contributions to the patient’s illness are fully explored”.²¹ Good himself attributed an increase in the discharge rate to the methods of psychotherapy used at the Littlemore, which he insisted were “essential in the treatment of mental illness”, although physical treatments were also administered.²² He noted that

¹⁶ Postel and Quétel, *Nouvelle Histoire De La Psychiatrie*, 352. See also: Aude Fauvel, “Aliénistes contre psychiatres: la médecine en crise (1890-1914),” *Psychologie Clinique* no. 17 (2004): 61-76.

¹⁷ Twenty-fifth Annual Report of the BoC, 1937/8, 16.

¹⁸ J. Stewart, “Tackling Shell Shock in Great War Oxford: Thomas Saxty Good, William McDougall, and James Arthur Hadfield,” *Canadian Bulletin of Medical History* 33, no. 1 (2016).

¹⁹ BoC Report, LARs, 1929/30, 16. OHA-L1/A2/7.

²⁰ BoC Report, LARs, 1925/6, 16. OHA-L1/A2/3.

²¹ BoC Report, LARs 1933/4, 18. OHA-L1/A2/10.

²² Good, “History and Progress,” 614.

between 1911 and 1915, the average number of patients stood at 657, whereas between 1922 and 1930, the average was 514.²³

Good established an outpatient clinic for nervous disorders at the Radcliffe Infirmary in 1918, one of the few clinics of its kind at the time, as well as Oxford's City Education Clinic for children with learning difficulties or behavioural problems. There was a steady increase in the number of out-patients attending the clinics during the interwar period, that corresponded with a reduction in the numbers of admissions, particularly amongst young adults, who were able to remain living, and working, in the community. The BoC noted in 1936 that the two outpatient clinics were "providing for a large section of the mentally sick, who, under other circumstances, would be mental hospital patients" and that many children were being "saved from becoming psychotics in later life".²⁴ Both clinics continued "to serve a useful function" after Good's retirement in 1936, and attendances remained high.²⁵ Dr Armstrong, Good's successor at the Littlemore, remarked on recent praise for "Out-patient Clinics in the treatment of early mental conditions of both children and adults", noting that Oxford had "long been amply served by both types of Clinic" thanks to the enlightened policy of Dr Good.²⁶

Littlemore patients enjoyed considerable liberty, which was highly unusual for mental hospitals. When the Littlemore re-opened for civilian use in 1922, Good was determined to "resort as little as practicable to the locking of doors".²⁷ The BoC's inspectors noted that very few wards were locked, windows could be opened freely and there were very few walls or fences, which was most unusual in mental hospitals.²⁸ The absence of locks, Good believed, removed the sense of "restlessness ... so common in people under compulsory confinement".²⁹ It also suggested to patients that "they [were] to be trusted to assist in their own recovery" and developed within the patient a sense of responsibility and control. This was reinforced by removing to a locked ward those patients who disobeyed the rules.³⁰

²³ Ibid.

²⁴ BoC Report, LARs, 1936/7, 17. OHA-L1/A2/14.

²⁵ MS Report, LARs, 1937-8, 11. OHA-L1/A2/15.

²⁶ MS Report, LARs, 1938-9, 14. OHA-L1/A2/16.

²⁷ BoC Report, LARs, 1937/8, 16. OHA-L1/A2/15.

²⁸ BoC Report, LARs, 1926/7, 14. OHA-L1/A2/4.

²⁹ Good, "History and Progress," 612.

³⁰ Ibid.

In 1925, the Board's inspector noted that 60 male patients and 82 female patients were free to wander around the estate, and 16 men and 27 women could walk outside the hospital grounds unattended each week.³¹ In 1930, only 18% of men and 19% of women were in locked wards.³² This policy was consistent throughout the period; in 1938, 56 men and 120 women were allowed to roam in the grounds, while parole outside the grounds was granted to 30 men and 36 women [see Table 27 below]. 125 men and 250 women had unrestricted access from their unlocked wards to the ward gardens.³³ Littlemore patients were taken for walks and on shopping trips, from which they returned "cheerful and happy" according to the BoC's inspectors.³⁴ Many patients were allowed to roam around the estate.³⁵ The BoC were also impressed by the "excellent practice ... of allowing patients out on trial to test their capacity for discharge" which was an important means of rehabilitation.³⁶ The "open door system ... manifestly contributes greatly to the wellbeing of patients" and helped to dispel feelings of "confinement and detention".³⁷

Table 27: This table shows the numbers of Littlemore patients on both full and limited parole:

	1923	1924	1925	1926	1927	1928	1929	1930
<i>Full parole:</i>	34	40	59	68	86	66	57	58
Men	15	16	25	34	38	30	25	25
Women	18	24	34	34	48	36	32	33
<i>Hospital Grounds only:</i>	108	115	190	356	313	362	369	366
Men	44	50	75	106	100	106	106	106
Women	64	65	115	250	213	256	263	260

Table 27 continues overleaf for the years 1931-9...

³¹ BoC Report, LARs, 1925/6, 16. OHA-L1/A2/3.

³² Good, "History and Progress," 612.

³³ MS Report, LARs, 1938/9, 7. OHA-L1/A2/16.

³⁴ BoC Report, LARs, 1926/7, 14. OHA-L1/A2/4.

³⁵ Ibid.

³⁶ BoC Report, LARs, 1923/4, 14. OHA-L1/A2/1.

³⁷ BoC Report, LARs, 1929/30, 14. OHA-L1/A2/7.

	1931	1932	1933	1934	1935	1936	1937	1938	1939
<i>Full parole:</i>	52	63	74	65	62	66	60	66	55
Men	24	28	30	30	26	30	30	30	25
Women	28	35	44	35	36	36	30	36	30
<i>Hospital Grounds only:</i>	363	307	322	365	345	360	184	176	169
Men	100	105	102	105	105	110	80	56	53
Women	263	202	220	260	240	250	104	120	116
<i>Ward Gardens only:</i>		-	-	-	-	-	375	375	616
Men							115	125	184
Women							260	250	432

The Littlemore's "open door" policy was in marked contrast to that of the ADLS, which remained a "closed" establishment. Dr Schultzenberger remarked in 1933 that the danger of escape posed by working outdoors limited the number of male patients who could be given work in the open air, despite its therapeutic advantages.³⁸ He felt that the temptation to escape was greater at an asylum situated near the centre of a town, as the ADLS was.³⁹ Perhaps this perceived danger also curtailed the trips into town and picnics that were organised for patients before World War I. Staff shortages and overcrowding may also have precluded opportunities to take patients out of the asylum. The Littlemore's policy was radical when the hospital re-opened in 1922 and acted as a "guiding light" for other English mental hospitals.⁴⁰ The method paved the way for a less custodial approach, towards one that treated patients as regular hospital patients, rather than as inmates.

In contrast to the Littlemore, the ADLS, where overcrowding was a recurrent complaint, had no outpatient department to treat patients at the early stages of their mental disorder, or "open services" to enable the voluntary inpatient treatment. In any case, as Dr Christy (CMO of the ADLS 1935-8) observed, "open services" might not have been appropriate in the department of La Sarthe whose high proportion of rural inhabitants rarely sought medical advice. The occupation and life-style of peasant farmers, in Christy's opinion, meant that

³⁸ Rapport du Médecin en Chef, ADLS, 1933 [no page nos.]. ADS-1X261.

³⁹ Ibid.

⁴⁰ McCrae and Nolan, *The Story of Mental Nursing in British Mental Hospitals*, 71.

they were less likely to seek help for mental illness voluntarily than urban dwellers.⁴¹

Christy, who was responding to the Ministerial Circular of 1937, agreed that early treatment was essential, particularly for cases of GPI and dementia praecox, which would benefit from the early administration of malaria therapy and shock treatments respectively. However, the delivery of any form of treatment was nigh on impossible at the ADLS with only one doctor for 900 patients.⁴² Assistance for “abnormal children” was also an urgent issue for La Sarthe, where there were “many delinquent and criminal young men requiring psychiatric attention”.⁴³ But at the ADLS, even if the finances had been available, there was no space to build any additional facilities.⁴⁴ Until after World War II, when these medical, economic and practical difficulties could be addressed, the ADLS would remain a “closed” hospital for both acute and chronic cases, and mainly the latter.

6.5 Staffing and Approaches to Treatment

6.5.1 Chief Medical Officers and Medical Superintendents

The therapeutic preferences of the MS and CMOs influenced the extent to which patient work and occupation was valued in a general sense and, more specifically, to which patients it was prescribed. The long-standing MS of the Littlemore and the CMOs of the ADLS had quite different therapeutic approaches, which were related to the different pathways of development taken by French and British psychiatry discussed in chapter three. The different approaches were reflected in their prescription of patient work. Dr Thomas Saxty Good, MS of the Littlemore 1906-1936, as we have seen, put great faith in psychotherapy, while the CMOs⁴⁵ of the ADLS took a more “biological” approach. Psychotherapy became the main method of treatment at the Littlemore after 1922, when the hospital opened for civilian use, along with hydrotherapy, “work therapy” and amusements.⁴⁶ The BoC commented on Good’s “judicious exercise of psychotherapy in conjunction with close study

⁴¹ Rapport du Médecin-en-Chef sur l’Étude prescrite par M. le Ministre de la Santé Publique pour l’extension de la prophylaxie mentale, Le Mans 18/02/1938. ADS-1X952.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ The CMOs of the ADLS during the interwar period were Dr Victor Bourdin (1904-32); Dr Schutzenberger (1932-4); Dr Henry Christy (1935-9) and Dr Hédouin (1939-45)

⁴⁶ Good, “History and Progress,” 614.

of physical conditions”.⁴⁷ While drug treatments were not eschewed, the BoC noted with approval the Littlemore’s “sparing use of sedatives”.⁴⁸

Good confirmed in 1930 that sedatives, narcotics and hypnotics were used, but only for extreme cases. He claimed that 15 female patients (or 2% of the average daily number resident), but no males, were given paraldehyde (a hypnotic drug used to treat insomnia) continuously throughout the year, while bromides (used to control the seizures associated with epilepsy, a neurological condition) were given in 48% of male epileptic cases and 38% of female epileptics. Two dozen tablets of “dial” and an equal number of “didial” were administered during the year, but no other barbiturates. Hydrotherapy was used for cases of confusional excitement.⁴⁹ Good maintained that as a “matter of practice” all methods of treatment were tried at the Littlemore, but he had found that “mental analysis” was the “most certain”.⁵⁰ Occupation complemented this re-educative approach.

Good used psychotherapy not only in his treatment of patients, but also in his dealings with members of staff.⁵¹ Psychotherapeutic principles permeated Good’s management style. Because he believed that all departments of the hospital, including the kitchen, laundry, stores and offices, contributed to the well-being of patients, Good insisted on close communication between them. While units operated independently, there was “frequent discussion amongst the various head of units”. In this way, “every person in the hospital staff has an opportunity of hearing the ideas of others, and therefore perceives not only the effect of his own unit, but of others”.⁵² This was an important factor when patients were working all over the hospital, assisting in various departments where they might not be medically supervised. As for the nursing staff, Good ensured that nurses were freed from administrative duties in the laundry and kitchen so that they could spend more time with patients.⁵³ He made it a priority that nurses were not only able to deal with physical aspects

⁴⁷ BoC Report, LARs, 1925/6, 14.

⁴⁸ BoC Report, LARs, 1929/30, 14.

⁴⁹ Good, “History and Progress,” 618.

⁵⁰ *Ibid.*, 621.

⁵¹ *Ibid.*, 614.

⁵² *Ibid.*, 613.

⁵³ *Ibid.*, 614.

of illness, but also to “sympathise with the psychological disposition of the individuals under their care”.⁵⁴

Described by the *British Medical Journal* as “one of the pioneers of modern psychiatry”, Good’s approach was endorsed by his appointments as lecturer in psychiatry and nervous disorders at the University of Oxford in 1928, as President of the Medico-Psychological Society in 1930 and of the British Medical Association’s Section on Neurology and Psychological Medicine in 1936.⁵⁵ His approach was continued by Dr Armstrong on his retirement in 1936. At this time, many more biological treatments were beginning to be explored, raising the question of whether psychotherapy, reinforced with occupation, remained an important means of therapy. From the Littlemore’s annual reports, it appears that Dr Armstrong was keen to trial these new treatments, but psychotherapy remained a priority at the Littlemore, indicating that a psychobiological approach continued to be adopted. Dr Armstrong reported in 1938 that malaria therapy was being continued and had produced very satisfactory results in several cases.⁵⁶ Good had mentioned in 1926 that the effects of malaria therapy on cases of GPI and encephalitis had been trialled by his medical team,⁵⁷ but he did not mention it in subsequent annual reports, nor in his history of the Littlemore. Dr Armstrong’s comment, however, suggests that its use had been on-going. The 1938/9 report also referred to the use of shock therapy in the treatment of schizophrenia. Cardiazol had been used at the Littlemore and Dr Armstrong hoped to try other forms of convulsive drugs such as Triazol.⁵⁸ He had not been able to attempt insulin therapy due to a shortage of medical staff, but this would be considered once a third Assistant MO had been appointed.⁵⁹ This appointment, the BoC believed, was justified in the light of the number of acute patients being admitted on a voluntary basis; the need for thorough and sometimes prolonged investigation; and the time taken up with psychotherapy at the Littlemore.⁶⁰ The latter comment suggests that psychotherapy remained a significant method means of therapy.

⁵⁴ Ibid., 615.

⁵⁵ E.M., “Obituary: T. Saxty Good, OBE, MRCS,” *British Medical Journal*, 24 Nov (1945): 747.

⁵⁶ MS Report, LARs, 1938/9, 15. OHA-L1/A2/16.

⁵⁷ MS Report, LARs, 1926/7, 11. OHA-L1/A2/4.

⁵⁸ Triazol was another form of fit-inducing drug that had fewer unpleasant side effects than Cardiazol.

⁵⁹ MS Report, LARs, 1938/9, 15.

⁶⁰ MS Report, LARs, 1938/9, 16.

The year 1939 was reported as “exceedingly active” from the point of view of the medical treatment of patients. A “large number” of patients were treated with various forms of shock therapy and “nearly a dozen” with insulin therapy resulting in “a few striking successes and a great many disappointments”.⁶¹ More success had been achieved using continuous narcosis, which Armstrong believed was “definitely a useful addition to the therapeutic armamentarium”.⁶² On balance, however, he considered that these “heroic measures of treatment” were “unlikely to realise the high hopes with which they were introduced”.⁶³ His ongoing commitment to OT, on the other hand, was indicated in the reports from 1936/7 to 1939/40. These revealed that OT provision had expanded both in terms of the numbers of patients involved and the range of items produced. He confirmed that this “important form of treatment” was being provided for “all grades of patients” including those at the agitated, acute stages of their illness.⁶⁴ Occupation was therefore being used to treat curable cases as well as to distract the more turbulent, incurable patients. Armstrong appeared equally supportive of OT as his predecessor.

The Littlemore had just two superintendents during the interwar period; Good and Armstrong, both of whom valued psychotherapy and occupation. Although Armstrong was more open to modern biological interventions, both he and Good valued and encouraged occupational therapy. In contrast, while the ADLS enjoyed continuity of medical leadership until the retirement of Dr Bourdin in 1931, during the 1930s three CMOs were appointed in fairly rapid succession. None of these CMOs mentioned psychotherapy and all appeared to favour biological interventions for curable cases, in line with their organicist principles. Bourdin’s reports were dominated by his trials of new medicines, such as Borosodine to treat epilepsy, the hypnotic somnifène, and Gardénal, but the results were not promising.⁶⁵ The families of some GPI patients had asked Bourdin to experiment on their relatives with anti-syphilitic treatments based on bismuth or arsenic, but he felt that, apart from being very expensive, these drugs were risky to the patient and only gave temporary relief. Bourdin prescribed them if relatives insisted, however.⁶⁶ The fact that patient work was not

⁶¹ BoC Report, LARs, 1939/40, 22. OHA-L1/A2/17.

⁶² MS Report, LARs, 1939/40, 11.

⁶³ MS Report, LARs, 1939/40, 11.

⁶⁴ MS Report, LARs, 1937/8, 7-8.

⁶⁵ Rapport du Directeur et Rapport Médical, ADLS, 1922, 35-6. ADS-1X964.

⁶⁶ Rapport du Directeur et Rapport Médical, ADLS, 1923, 35. ADS-1X964.

mentioned in Bourdin's reports, while his use of various drugs was paid significant attention, suggests that Bourdin preferred biological to psychological methods of treatment, in keeping with French psychiatric tradition. The records appended to the ADLS accounts, however, indicated that patient work was occurring on a similar scale to before World War I. It can be assumed that this patient work was carried out by calm, chronic patients and convalescents (as was the practice before the war) and that occupation was not being used to treat acute patients.

When Dr Schutzenberger arrived in Le Mans from the Asile Clinique in Paris, becoming CMO of the ADLS in 1932, he was keen to offer "complete, effective and modern treatment" using the full range of therapeutic methods available.⁶⁷ Additional credit granted by the AD enabled him to purchase the equipment required to perform blood tests, lumbar punctures and the examination of liquids that would allow biological tests, such as the Bordet-Wassermann test for syphilis, to be undertaken.⁶⁸ Schutzenberger, taking advice from his former senior colleagues at the Asile Clinique, Drs Guiraud and Truelle, introduced malaria therapy to the ADLS in 1933. Henceforth, he maintained, this method would be used to treat all GPI sufferers. Rates of cure and improvement for 1933-5 did not show a significant improvement, however. Schutzenberger's medical report of 1933 was the first interwar medical report to mention patient work, itemising the numbers of days worked in each category, and the breakdown of work between male and female patients.⁶⁹ The therapeutic value of work was not mentioned, however, nor was there any indication that acute patients were given any form of occupation.

When Dr Christy took over as CMO in 1934, his first report was designed to impress upon the prefecture the "scientific trends" that guided his treatment methodology.⁷⁰ His emphasis of the scientific nature of his methods is indicative of higher professional standards to those of his predecessors. He divided patients into two categories, the intellectually impaired, who were incurable, and the mentally disordered, who responded to treatment. The two categories required different therapeutic techniques. The intellectually impaired required treatment for any physical ailments; support; comfort; and the re-

⁶⁷ Rapport du Médecin en Chef, ADLS, 1933 [no page nos.].

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ Rapport du Médecin en Chef, ADLS, 1935, 7.

education or moral discipline provided by work. The mentally disordered, on the other hand, required “aggressive biological treatment”.⁷¹ The two types of treatment required different skill sets of the doctors. When treating the intellectually impaired, the doctor had to be a psychologist, while the skills of a neuro-psychiatrist were required to treat the mentally disordered.⁷² Christy’s preference for a neuro-psychiatric approach towards treatment of acute cases underscores French psychiatry’s lack of independence from neurology. Christy made it clear in 1936 that he was more interested in neuro-psychiatry than psychological medicine.⁷³ He wanted to focus on treating acute cases, but the demands of modern (biological) medicine made this difficult with so many patients under the care of just one doctor.

Although Christy emphasised biological treatments for curable patients in his reports, he also made several references to patient work in a rare outline of specific cases presented in 1935. A 19-year-old woman, Berthe, was diagnosed with dementia praecox. She recovered after shock treatment and was reported to have been “docile and working”. Berthe then contracted pleurisy, but on recovering from this illness she returned to regular work and was soon able to leave the asylum. Patient P.J., aged 21, also suffering from dementia praecox, improved considerably after shock treatment and was currently working at the asylum. His family were going to take him home in a short while. Mme D., 42, suffered from acute depression and had attempted suicide. She was malnourished and deficient in vitamins. She recovered, and after receiving the appropriate food, she returned home and was able to take up her profession as a market trader once more.⁷⁴ The first two cases indicate that Christy prescribed work for patients who were convalescing, following successful shock treatment. The third case indicates that Christy regarded a patient’s ability to return to work as evidence of recovery. An ability to work was considered a requirement for discharge, as indicated by the annual examination records of patients throughout the interwar period. These revealed that if a patient was unable to work and had no-one at

⁷¹ Ibid.

⁷² Ibid.

⁷³ Rapport du Médecin en Chef, ADLS, 1937, 12.

⁷⁴ Rapport du Médecin en Chef, ADLS, 1935, 10. ADS-1X965.

home to support him/her, the patient should remain in the asylum. The phrase “à maintenir” appeared next to their record.⁷⁵

Dr Hédouin, who took over from Christy in 1939, agreed that one CMO could only deal with the most pressing cases and that it was impossible to follow the progress of each patient.⁷⁶ Following the outbreak of World War II, patient numbers at the ADLS had swelled to over 1,000. Le Mans had been invaded by the Germans and the ADLS was obliged to admit patients evacuated from a neighbouring hospital, Dury-les-Amiens. Hédouin found it impossible to categorise or separate patients. Acute psychopaths were adjacent to the intellectually impaired and impressionable adolescents were housed with the medico-legal cases.⁷⁷ The accounts show that patient work continued throughout 1939; presumably its contribution to asylum maintenance and food production was extremely important during the Occupation when conditions were harsh and most French mental hospitals were deprived of food and other essential resources.⁷⁸

The focus of the interwar CMOs of the ADLS was biological or physical treatment rather than psychotherapy or occupational therapy, particularly for acute patients, although patient work was prescribed to the chronic, incurable and convalescent patients. Psychotherapy, as the English BoC observed, was time-consuming, and a single CMO in charge of between 600 and 1,000 patients did not have time to deliver it. But neither was psychotherapy an area of interest for the succession of CMOs who came to the ADLS. Christy actually stated his preference for neuro-psychiatry. This preference for biological interventions appears to have influenced the CMOs' views on patient occupation. Christy felt that work was appropriate for incurable patients, while the curable were to receive “aggressive biological treatment”, followed by work during their convalescence. There was no question of developing occupations for those who were confined to bed, or for other patients whose conditions precluded work around the hospital. However, the ability of the ADLS CMO to recruit interns and medical officers compromised the provision of biological treatment for

⁷⁵ Guillemain, *Chronique De La Psychiatrie Ordinaire*, 45.

⁷⁶ Rapport du Médecin en Chef, ADLS, 1939 [no page nos]. ADS-1X965.

⁷⁷ Ibid.

⁷⁸ Comptes Administratifs, ADLS, 1939. ADS-1X964.

patients. By 1939, when Hédouin joined the ADLS, overcrowding and understaffing as a result of the war meant that little active treatment of any kind could be delivered.

6.5.2 Nursing Staff

Neither the Littlemore nor the ADLS employed an occupational therapist. The overseeing of patient occupation fell to the nursing staff. The training and aptitudes of the nurses, and the amount of time they had to spend with patients, were important factors in the delivery of therapeutic work and OT. The Littlemore and the ADLS differed quite markedly in terms of nurses' training and skills, which were of a much higher standard at the Littlemore. Here, Dr Good expected every nurse to learn a craft which they could teach to patients. By developing a rapport with patients, nurses were able to encourage them take up the craft in which they specialised. As Good put it, a patient's attachment to a nurse "will often induce them to start that nurse's particular craft".⁷⁹ The BoC inspectors were impressed by the fact that nurses on "both sides" were expected to learn and teach handcrafts to patients and that in so doing, produced "detailed and helpful notes ... on the behaviour and conversation of patients" which aided the doctors in their treatment decisions.⁸⁰ Doctors discussed each case fully with the senior nurses and involved them in decisions regarding treatment.⁸¹ The hospital did not suffer from overcrowding (attributed to the existence of the outpatient clinic) which allowed the nursing staff to maximise the amount of time spent with patients, engaging them in conversation and helping them with their craft activities.

At the ADLS, on the other hand, it was difficult to find reliable, experienced male nursing staff who could supervise patient work at all but the most rudimentary level. Staff shortages were compounded by overcrowding, which meant that nurses had less time to spend with patients. On the female side, nurses were provided by the Charité d'Evron as a result of a long-standing arrangement between the Prefect of La Sarthe and the Mother Superior of the religious order.⁸² Whilst the service these "sisters" provided was always good, there was

⁷⁹ Good, "History and Progress," 614.

⁸⁰ BoC Report, LARs, 1933/4, 19.

⁸¹ Good, "History and Progress," 615.

⁸² Guillemain, *Chronique De La Psychiatrie Ordinaire*, 39.

a lack of continuity of care because the nurses had their religious duties to attend to as well as their nursing duties. Therefore, unlike at the Littlemore, where nurses had the time and training to oversee and encourage patient occupation, at the ADLS, a lack of training on the male side, coupled with time constraints and a lack of continuity on the female side, meant that patients received less attention.

In 1920 the ADLS had barely enough staff to give nurses a rest day every week.⁸³ Despite a salary rise in 1920 which put the ADLS on a level with other, similar establishments, few applicants were able to satisfy the ADLS Asylum Director (AD)'s requirements for nursing experience gained at other local hospitals or asylums.⁸⁴ Those who were recruited did not remain long in post, which was unsettling for patients.⁸⁵ It had not been possible to institute the eight-hour day for nurses in 1919 (although it had been applied to administrative staff) because recruitment was so difficult. Splitting the nursing teams into three would have been impossible, since the existing teams were rarely complete. The AD rather disparagingly observed that "a good nurse, let us say, is the exception" and it was probably unwise to allow nurses 16 hours of liberty because they would probably abuse it!⁸⁶ These comments lend weight to the criticisms of nursing staff made by Paul Courbon in 1929.⁸⁷ The nursing situation at the ADLS was therefore in marked contrast to that at the Littlemore, where nurse training was supplemented by a period spent at the Radcliffe Infirmary, a general hospital.⁸⁸ The BoC remarked that nurse training at the Littlemore was "calculated" to ensure that nurses could provide "valuable co-operation" in the treatment of patients.⁸⁹

Probationer nurses at Littlemore underwent training by Dr Good, his MOs and the Matron and Head Male Nurse, according to the syllabus for mental nurses laid down by the RMPA, which included a section on patient occupation. Nurses took their preliminary examinations after 18 months and their finals after three. Nurses who passed their final examinations were "certificated" by the RMPA or became "registered" with the General Nursing Council if they had opted to sit the GNC examinations. Approximately 40-45% of Littlemore nurses

⁸³ Rapport du Directeur, ADLS, 1920 [no page nos.]. ADS-1X965.

⁸⁴ Ibid.

⁸⁵ Rapport du Directeur, ADLS, 1923, 10. ADS-1X965.

⁸⁶ Rapport du Directeur, ADLS, 1919 [no page nos.]. ADS-1X965.

⁸⁷ Courbon, "Un Voyage d'Études," 399.

⁸⁸ Good, "History and Progress," 615.

⁸⁹ BoC Report, LARs, 1929/30, 14.

were registered or certificated. Examination results were highlighted each year by the MS or BoC inspectors in the hospital's annual report. For example, in 1936, nine male nurses and 16 female nurses were reported to have passed their preliminary examinations, while six women and one man passed their finals, one woman gaining a distinction. General training was supplemented at the Littlemore by a system of nurse exchange between the Littlemore and the Radcliffe Infirmary, enabling Littlemore nurses to gain experience of physical illness and Radcliffe nurses to learn something of mental nursing.⁹⁰

Nurses at the Littlemore had more to offer their patients in terms of skills, time and empathy than those at the ADLS. From Dr Good's article in the *JMS* and from the hospital's annual reports, most of the nursing staff at the Littlemore were dedicated and genuinely interested in their patients. Both male and female nurses were willing to learn a craft that they could teach to patients, and in this they were encouraged by the medical staff who recognised the benefits of keeping patients "of all grades" occupied. At the ADLS, nurses lacked the time and the knowledge to become involved in patient occupation, and this was not an area that appeared to be prioritised by the ADLS CMOs. The latter were more concerned with focusing their limited resources on biological treatments for acute cases. That said, patient work continued to be prescribed for chronic patients, for whom it was considered beneficial in a re-educative sense, and for convalescent patients.

6.5.3 Staff-to-Patient Ratios

While nursing skills and training were essential to the delivery of appropriate levels of care, staff numbers were also key. At the ADLS, an insufficient quantity of nurses, and junior medical staff, compromised treatment. In 1933, the new CMO Dr Schutzenberger highlighted that although "on paper" there might be an appropriate number of patients per nurse, in reality, the actual number of nurses was insufficient. Nurses were often required to be somewhere other than the patients' quarters, such as supervising bathing; and days off and holidays had to be taken into consideration. In the Men's Division, there were 335 patients and 42 nurses, but only 26 of these were on the wards at any one time, giving a ratio of one nurse to 13 patients. On the women's side, there were 496 patients and 43 sisters, but one worked in the pharmacy and two more supervised bathing, giving a ratio of

⁹⁰ MS Report, LARs, 1929/30, 12; Good, "History and Progress," 615.

one nurse to 12 patients. Lack of continuity of service amongst the sisters added to the problems caused by the patient to staff ratio.⁹¹ The introduction of the 40-hour week in 1937 forced the ADLS to increase the number of male nurses from 46 to 125. Many of the new recruits had no experience of nursing.⁹² The CMO, Dr Christy, was compelled to organise courses for all male nurses, including elementary instruction in anatomy, physiology and hygiene, since he could achieve little if his staff lacked any understanding of and had scant interest in their work.⁹³ Until then, there was no formal nursing training at the ADLS. Nurses at the ADLS were unlikely to have the time, knowledge or inclination to become involved with patient occupation, other than delivering the patients for whom it had been prescribed to their places of work.

Apart from the workshop managers, there were no other members of staff who could have supervised OT (or biological treatments, for that matter). Dr Schutzenberger highlighted that it was impossible for a single CMO to treat c.850 patients without either a medical assistant or interns.⁹⁴ Christy admitted that he had only achieved modest results in the treatment of GPI⁹⁵ with malaria therapy because there were insufficient staff to carry out all the necessary procedures. Without additional medical staff Christy did not feel that he could offer the full range of modern treatments.⁹⁶ Until the mid-1930s, the CMO had been the only medically qualified member of staff. Le Mans was a small town without a university (at that time), which made the recruitment of interns difficult, although one had been engaged for a short period.⁹⁷ In this, the situation of the ADLS was quite different to that of the Littlemore, which was located in the university town of Oxford, where there was an abundance of medical students. Dr Christy was delighted to have a medical assistant in 1937 but having been without an intern for several months he had been forced to abandon some of the more labour-intensive therapies that he had begun. He concluded that without

⁹¹ The ratios of nursing and medical staff to patients at each of the six institutions studied are set out in Tables 3a-f in chapter four, pages 94-5.

⁹² Rapport du Médecin en Chef, ADLS, 1937, 13.

⁹³ Ibid.

⁹⁴ Rapport du Médecin en Chef, ADLS, 1933 [no page nos.].

⁹⁵ He also noted that there far fewer cases of GPI in Le Mans than Lyons, where he had practised before, leading him to conclude that the disease spread more slowly in rural areas.

⁹⁶ Rapport du Médecin en Chef, ADLS, 1937, 22.

⁹⁷ Ibid.

interns, he could not offer the modern treatments that he would like to use, particularly as he was also running courses for the male nursing staff.⁹⁸

Unlike Le Mans, the existence of the university in Oxford, made the recruitment of medical students for the Littlemore much easier. As the BoC highlighted in 1928, “Dr Good’s recent appointment as lecturer of psychiatry ... will undoubtedly benefit this Hospital, as the periodical introduction of keen medical students has always been found to be a stimulus to high class work”.⁹⁹ In addition to medical students, the MS was supported by two Assistant Medical Officers throughout the interwar period. The ratio of nurses to patients was also more favourable at the Littlemore, with one nurse to between seven and nine patients, while at the ADLS the ratio was one nurse to 12 patients. This meant that both medical and nursing staff had more time to spend with patients, and more time to supervise patient occupation. The MS highlighted the fact that Littlemore nurses were very dedicated and keen to further the work of the medical staff.¹⁰⁰ Continuity of care was indicated by the length of time several nurses remained at the Littlemore. In 1929, the MS announced that the Deputy Head Male Nurse, Henry Shattock, was retiring after 41 years of service. Four other male nurses also retired that year after working for between 30 and 35 years at the Littlemore.¹⁰¹ Good praised the “general excellence and almost universal good behaviour of the Staff” which he attributed to the “keenness and efficiency” of the Matron and Head Male Nurse.¹⁰² The BoC inspectors noted in 1934 that “the [senior] nurses with whom we spoke showed both knowledge and interest in their patients and the general standard of nursing appeared to us to be high.”¹⁰³ However, in addition to a plentiful supply of skilled, well-trained nurses and junior doctors, mental hospitals needed sufficient resources to function efficiently. Only with adequate resources could innovation in treatment (either biological or psychological) occur. Therefore, the introduction of OT depended in practice on the extent to which the asylum or mental hospital relied on the financial contribution made by patient work. This contribution was far less important to the Littlemore than to the ADLS.

⁹⁸ Ibid, 24.

⁹⁹ BoC Report, LARs, 1928/9, 16.

¹⁰⁰ BoC Report, LARs, 1926/7, 15-16.

¹⁰¹ MS Report, LARs, 1929/30, 12.

¹⁰² Ibid.

¹⁰³ BoC Report, LARs, 1934/5, 16.

6.6 The Economic Importance of Patient Work

Patient work provided an important means of offsetting running costs at the ADLS. Frequent references were made to the 'profits' generated by the asylum bakery and by agricultural exploitation in the AD's annual reports.¹⁰⁴ In 1920, the AD commented that the farm had given good results that year, saving the asylum considerable sums. Produce from the market gardens, piggery and poultry farm were evaluated at 85,971F, which, after deducting costs of 47,253F, generated a profit of 38,718F [as shown in Table 30, below].¹⁰⁵ The products, including bacon, eggs, chicken, fruit and vegetables, were all consumed on the premises. Nothing was wasted or sold. The AD did not feel that it was right to treat the cultivation of farm produce as a commercial venture from which to make a cash profit. Rather, it was a means of improving the condition of patients, from which the establishment could also benefit.¹⁰⁶ The costs savings made by producing the establishment's own bread and foodstuffs were clearly important to the asylum. Farming was the second largest employer of male patient labour, surpassed only by housework. Collectively, male patients gave between c.4,500 and 5,500 days' labour to market gardening and roughly 1,500 days' work in the farmyard per annum [see Table 28, below]. Patient labour in the bakery only accounted for c.300 days during the 1920s, increasing to c.600-700 days in the 1930s, but nonetheless obviated the need to employ additional staff in this area.

Having stressed the importance of agricultural produce to the ADLS, it must also be highlighted that there was not much land available for the purpose. Until 1903, the asylum had rented a small farm a few kilometres away from the asylum, but the lease had been relinquished partly because the farm was unprofitable, and partly because managing patients was difficult from a distance.¹⁰⁷ The asylum itself comprised 12 hectares of land, but eight of these were taken up by buildings and courtyards. There remained just four hectares for the market garden, which, according to the AD writing in 1936, was barely

¹⁰⁴ By profits is meant the value of the produce (evaluated according to local market rates) minus the associated costs, including the wages of employees, such as the gardener or bakery manager, the *pécule* of the working patients, raw materials such as seeds or flour, and other costs such as equipment, fertiliser, fencing etc.

¹⁰⁵ Rapport du Directeur, ADLS, 1920, 15.

¹⁰⁶ Ibid.

¹⁰⁷ Rapport du Directeur sur la Ferme d'Angevinière, Compte Administratif, 1902. ADS-1X961.

sufficient to supply the required quantities of fresh produce.¹⁰⁸ There was therefore no question of building on this land, either to relieve overcrowding or to add the isolation cells for dangerous patients called for by Dr Bourdin in 1931.¹⁰⁹ Losing the land would have serious financial implications, as well as compromising the asylum's provision of therapeutic work.¹¹⁰

The AD highlighted the functioning of the asylum workforce (*les ouvriers de l'Asile*) in his reports. The asylum workforce, which comprised workshop staff and patient workers, performed maintenance and repair work around the asylum and made essential items, such as shoes and clothing. On the male side, patients gave 300-600 days' labour to the shoemaking workshop, while maintenance work in the grounds accounted for c.1,500-2,000 days of patient labour. Sewing was the largest employer of female patients who contributed between c.13,000 and 15,000 days' labour to the sewing room, and a further 4,000-6,000 days' work to mending [see Tables 28 and 29 below]. Records were kept of all the items made in the sewing room. For example, in 1923, 190 pillow cases, 470 sheets, 67 mattress covers, 360 men's shirts, 499 women's blouses, 238 dresses, 152 pairs of trousers, and 1,622 handkerchiefs were made (among many other items) during the year.¹¹¹ Each was attributed a value; dresses, for example, were evaluated at 4F each, pillow cases at 0.50F, and handkerchiefs at 0.10F. Work that did not result in a tangible product, such as housework, was evaluated on the basis of a daily rate. Most tasks, including working in the laundry or knitting, were attributed a value of 1F per day, while more skilled work, such as clerical work, stone-masonry, painting, carpentry, locksmithing, and shoe-making, was evaluated at 1.50F per day.¹¹² The financial contribution made by patients, including the value of goods produced and work performed, shown in Table 30 (below), represented between c.5% and 11% of total asylum expenditure.

¹⁰⁸ Rapport du Directeur, ADLS, 1936, 4.

¹⁰⁹ Ibid.

¹¹⁰ Ibid.

¹¹¹ État des Produits en Nature, Compte Administratif, ADLS, 1923. ADS-1X964.

¹¹² These evaluations had not changed since before WW1.

Table 28: Table shows the number of days worked by ADLS male paying and pauper patients in each employment category for the years 1923, 1930 and 1937 (for all years, see full table in appendices):

MALES	1923	1923	1923	1930	1930	1930	1937	1937	1937
Type of work	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total
Farmyard	1,482	-	1,482	1,408	50	1,458	1,629	-	1,629
Bakery	110	172	282	334	-	334	612	-	612
Laundry	2,579	220	2,799	3,387	540	3,927	4,285	152	4,437
Woodyard	2,207	-	2,207	2,846	589	3,435	2,271	-	2,271
Shoe Making	532	-	532	308	-	308	-	306	306
Kitchen	1,606	566	1,606	1,438	308	1,746	2,090	-	2,090
Farming	4,539	-	4,539	4,296	619	4,915	5,139	410	5,549
Clerical Work	590	-	590	6,457	842	7,299	868	567	1,455
Tin-plate Making	314	-	314	1,176	-	1,176	306	-	306
Stone Masonry	292	-	292	492	-	492	767	301	1,068
Housework	5,377	414	5,786	232	-	232	10,733	684	11,417
Carpentry	572	-	572	462	-	462	437	229	666
Painting	228	-	228	-	-	-	561	-	561
Locksmiths	-	-	-	284	130	414	343	-	343
Exterior maintenance	1,817	-	1,817	1,365	290	1,655	612	-	612
TOTALS	22,240	1,372	23,612	24,485	3,368	27,853	30,653	2,669	33,322

Table 29: Table shows the number of days worked by ADLS female paying and pauper patients in each employment category for the years 1923, 1930 and 1937 (for all years, see full table in appendices):

FEMALES	1923	1923	1923	1930	1930	1930	1937	1937	1937
Type of work	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total
Farmyard	1,452	-	1,452	912	228	1,140	308	-	308
Laundry	3,822	-	3,822	3,838	-	3,838	4,443	153	4,596
Sewing	1,595	752	2,347	1,677	608	2,285	16,836	2,039	18,875
Kitchen	13,334	1,156	14,490	12,228	866	13,094	6,209	56	6,265
Lingerie	7,296	306	7,602	6,591	472	7,063	1,232	616	1,848
Housework	8,341	1,244	9,585	9,162	779	9,941	11,735	614	12,349
Pharmacy	612	-	612	760	-	760	308	-	308
Mending	5,096	178	5,274	6,313	289	6,602	3,571	580	4,151
Ironing	2,104	-	2,104	1,873	304	2,177	2,947	-	2,947
Knitting	2,119	497	2,616	532	678	1,210	6,279	837	7,116
TOTALS	45,771	4,133	49,904	43,886	4,224	48,110	55,334	5,208	60,537

Table 30: This table shows the value of goods produced ‘in kind’ (x) and of patient labour (y), and the total (z) expressed as a percentage of total asylum expenditure, at the ADLS:

Year	Revenue en Nature (x)	Travail des Aliénés (y)	X + Y = Z	Total expenditure	Z as % of Total Exp.
1919	50,265	33,078	83,343	923,894	9%
1920	60,731	50,270	111,001	1,345,689	8.2%
1921	87,204	55,630	142,834	1,511,191	9.5%
1922	95,289	60,999	156,288	1,619,019	9.7%
1923	106,304	66,007	172,311	1,529,616	11%
1924	116,521	60,960	177,481	1,633,652	10.9%
1925	121,994	67,158	189,152	1,610,620	11.7%
1926	135,529	64,780	200,309	2,042,720	9.8%
1927	153,498	60,736	218,309	2,352,401	9.3%
1928	142,564	63,810	206,374	2,370,067	8.7%
1929	147,063	67,486	214,549	2,932,546	7.3%
1930	139,338	63,942	203,280	2,797,749	7.3%
1931	148,013	66,163	214,176	3,187,855	6.7%
1932	138,308	69,320	207,628	2,776,108	7.5%
1933	137,579	69,473	207,052	2,836,554	7.3%
1934	176,051	75,779	251,830	2,855,111	8.8%
1935	165,875	71,311	237,186	2,932,788	8%
1936	187,590	78,272	265,862	2,792,421	9.5%
1937	239,029	77,629	316,658	7,072,670	4.5%
1938	308,954	77,514	386,468	5,694,461	6.8%
1939	271,924	80,234	352,158	6,353,049	5.5%

The most significant contribution to the asylum budget made by patient work in percentage terms (11.7%) occurred in 1925, a year of severe financial hardship for the asylum.¹¹³ The AD had warned the Prefect of the asylum’s precarious financial circumstance in 1924.¹¹⁴ In 1925, the situation was exacerbated by rising prices for essential items, particularly food. At the same time, patient numbers increased by 24.¹¹⁵ 1925 saw the highest proportion of patient workers indicated for the interwar period. The value of goods in kind and that of the work carried out by patients amounted to 189,152F and total asylum expenditure stood at 1,610,620F.¹¹⁶ The AD reported that a “tight rein” had been kept on expenditure during 1925.¹¹⁷ He did not mention having encouraged an increase in patient work, but the figures

¹¹³ Compte Administratif, ADLS, 1925. ADS-1X964.

¹¹⁴ Rapport du Directeur et Rapport Médical, ADLS, 1924, 11. ADS-1X964.

¹¹⁵ Rapport du Directeur, ADLS, 1925, 3.

¹¹⁶ Compte Administratif, 1925. ADS-1X964.

¹¹⁷ Rapport du Directeur, ADLS, 1925, 7.

indicate a significant rise in both the numbers of patient workers and the days worked, as indicated in Tables 31-34, below. In 1925, 63% of male pauper patients worked, as opposed to 59% in 1923 and 39% in 1927, and 32% of male paying patients worked a total of 3,803 days, as opposed to 20% who worked for 1,372 days in 1923. 58% of female pauper patients worked in 1925 which was the same percentage as the previous year, but in 1927 it fell to 53%. Amongst the female paying patients, 22% worked a total of 5,625 days in 1925, falling to 16% working a total of 4,100 days in 1927. The 23% of paying women who worked in 1923 only worked for a total of 4,133 days. These increased levels of patient work could be coincidental or related to other factors, such as the disposition or condition of patients. The fact that much of the additional work was carried out in farming, however, suggests an attempt to produce more of the asylum's own food during a period of high food prices. In 1925, 5,387 days were spent working on the farm, while in 1923 the figure was 4,539 and in 1927 it was 4,926. A similar peak in the level of patient work might be expected during, or just after, the financial crisis of 1931-2, but this was only significant amongst the male paying patients, 30% of whom worked in 1932 as opposed to 25% in 1930 and 19% in 1934.

Tables 31-34 show the proportions of male and female, pauper and paying, patients who worked at the ADLS. It is evident that a greater proportion of patients from the pauper category worked (on average 52.5% of pauper patients) than from the paying category (on average 22% of paying patients). Among the pauper patients, a slightly greater proportion of women worked (54%) than men (51%). This situation was reversed among the paying patients, where only 18% of paying women worked compared with 26% of paying men. That said, those paying women who worked, did so for a greater number of days than the men who worked (212 compared with 191). Pauper women also worked more days, on average, than their male counterparts (244 days compared with 222).

Table 31: This table shows the number of male and female pauper patient workers, expressed as a percentage of the total male and female pauper patient populations:

Year	Pauper males – total	Pauper male workers	% of pauper males working	Pauper females – total	No. of pauper female workers	% of working pauper females
1923	176	104	59%	334	193	58%
1925	187	119	63%	332	193	58%
1927	293	111	39%	345	182	53%
1929	225	103	46%	357	178	50%
1930	234	113	48%	359	179	50%
1932	242	117	48%	360	191	53%
1934	269	140	52%	355	199	56%
1936	261	140	54%	378	204	54%
1937	272	133	49%	389	199	51%
Averages			51%			54%

Table 32: This table shows the number of paying patient workers, expressed as a proportion of total paying patient population:

Year	Paying males – total	Paying male workers	% of paying males working	Paying females – total pop	No. of paying female workers	% of working paying females
1923	35	7	20%	96	22	23%
1925	60	19	32%	113	25	22%
1927	72	29	40%	116	19	16%
1929	66	22	33%	129	20	16%
1930	67	17	25%	131	21	16%
1932	57	17	30%	143	20	14%
1934	79	15	19%	140	28	20%
1936	77	16	21%	138	23	17%
1937	79	14	18%	123	21	17%
<i>Averages</i>			26%			18%

Table 33: This table shows the average number of days worked each year by paying patients:

Year	Total no. male paying patient workers	Total no. days worked by male paying patients	Average no. days worked per male paying patient	Total no. female paying patient workers	Total no. days worked by female paying patients	Average no. days worked per female paying patient
1923	7	1,372	196	22	4,133	188
1925	19	3,803	200	25	5,625	225
1927	29	3,888	134	19	4,100	216
1929	22	3,595	163	20	4,046	202
1930	17	3,368	198	21	4,224	201
1932	17	3,434	202	20	3,840	192
1934	15	3,510	234	28	5,788	207
1936	16	3,163	198	23	5,178	225
1937	14	2,669	191	21	5,203	248
<i>Averages</i>			191			212

Table 34: This table shows the average number of days worked each year by pauper patients:

Year	Total no. male pauper patient workers	Total no. days worked by male pauper patients	Average no. days worked per male pauper patient	Total no. female pauper patient workers	Total no. days worked by female pauper patients	Average no. days worked per female pauper
1923	104	22,240	214	193	45,771	237
1925	119	24,103	203	193	44,143	229
1927	111	24,277	219	182	41,665	229
1929	103	24,288	236	178	43,929	247
1930	113	24,485	217	179	43,886	245
1932	117	26,852	230	191	47,086	247
1934	140	30,896	221	199	47,015	236
1936	140	32,360	231	204	51,201	251
1937	133	30,653	230	199	55,334	278
<i>Averages</i>			222			244

At the Littlemore, records were no longer kept of the numbers of patients who were “usefully employed” as the BoC had sought to downplay the financial contribution made by patient work¹¹⁸ and to focus instead on therapeutic occupation. However, the sums raised by the sale of farm produce and the value of food supplied to hospital by the farm were still recorded in the hospital accounts, indicating that the production of foodstuffs continued to make a financial contribution to the hospital budget [see Table 35].

Table 35: This table shows the value of food supplied to hospital (x) and value of produce sold (y), and the total (x + y) expressed as a percentage of Littlemore’s total annual expenditure.

Year	1923	1925	1926	1927	1928	1929	1930	1931
Total hospital expenditure	£48,946	£62,281	£69,011	£69,515	£70,580	£70,237	£69,762	£68,311
Value of food supplied by farm (x)	£1,387	£1,345	£1,410	£1,282	£1,354	£1,128	£1,371	£1,368
Sale of farm produce (y)	£434	£598	£1,208	£755	£924	£713	£521	£417
Total of x + y % of Total Exp.	£1,821 = 3.7%	£1,943 = 3.1%	£2,618 = 3.8%	£3,319 = 4.8%	£2,278 = 3.2%	£1,841 = 2.6%	£1,892 = 2.7%	£1,785 = 2.6%

Year	1932	1933	1934	1935	1936	1937	1938	1939
Total hospital expenditure	£68,554	£49,949	£61,702	£52,841	£55,732	£58,767	£59,286	£60,132
Value of food supplied by farm (x)	£1,317	£1,404	£1,424	£1,205	£1,224	£1,539	£1,394	£1,624
Sale of farm produce (y)	£490	£685	£481	£362	£16	£377	£637	£797
Total of x + y % of Total Exp.	£1,807 = 2.6%	£2,089 = 4.2%	£1,905 = 3.1%	£1,567 = 2.97%	£1,240 = 1.8%	£1,916 = 2.7%	£2,031 = 2.9%	£2,421 = 3.5%

Patient involvement in the farm was indicated by Good’s remark that the only change to this department was “the increasing difficulty of getting patient labour” since so many of the new admissions were suffering from “severe physical illness” and were “quite incapable of being employed in any hard or continuous occupation”.¹¹⁹ The focus of Dr Good’s reports on patient occupation was on the introduction of craft activities, such as raffia-work and basket-making, as a means of occupying patients who did not perform the regular work of the asylum. That other work was going on was suggested by the BoC’s observation in 1934 that over a third of female patients were employed in craft work, and that this excluded

¹¹⁸ This, as indicated in chapter 4, was made explicit in 1928.

¹¹⁹ MS Report, LARs, 1926/7, 12.

“those employed in housework, kitchen, laundry or sewing work”.¹²⁰ A nurse who joined the Littlemore staff in 1926, remarked that the nurses had to keep patients occupied; if patients were idle the nurses got into trouble.¹²¹ Patients who could work, she remembered, polished the floors and tables, and worked in the kitchens or the gardens, while those confined to the wards kept busy with knitting, crochet and rug-making. The nurse noted that “patients weren’t any trouble if they were busy”.¹²²

There did not seem to be a clear divide between what might be considered OT and what constituted work. For example, two new occupations had been added to the repertoire of male patients’ activities in 1925/6; basket-making and concrete brickmaking. Basketry might fall into the category of OT, while making bricks, which were used in the construction of a new mess room, might be classified as work. In the absence of an occupational therapist to supervise certain activities (and not others) no such distinction was made. Both occupations, according to Dr Good, were “of assistance in treatment”. The BoC was most enthusiastic about the brick-making, suggesting that if the activity continued to be successful, patients might be taught how to make concrete curbing for the paths in the ward gardens.¹²³ The BoC noted that some of the chairs and sofas need re-upholstering and suggested that the upholstery workshop be re-opened (it had been closed before the war). Upholstery might prove to be “a valuable addition to the occupations carried on the male side”.¹²⁴ It would also save the hospital the expense of paying a commercial upholsterer to undertake the work. Other examples of “useful work” included the making of cotton-wool swabs for use at the Radcliffe Infirmary by female patients and the manufacture of a complete set of folding tables for the Recreation Hall by male patients.¹²⁵ These types of occupations, although they saved the hospital money, were not evaluated financially as they were at the ADLS. This suggests that the Littlemore was further ahead in its development as a treatment hospital, with OT and work regarded as treatments, than the ADLS.

¹²⁰ BoC Report, LARs, 1934/5, 16.

¹²¹ Interview with former nurse, Littlemore History Project, Oral History Interview by J.Goddard (1994/5). OHA/L1/OT232.

¹²² Ibid.

¹²³ BoC Report, LARs, 1925/6, 14-15.

¹²⁴ BoC Report, LARs, 1935/6, 16.

¹²⁵ MS Report, LARs, 1938/9, 8.

The blurred distinction between work and OT raises the question of how different types of occupation were allocated to patients. The presence of a significant proportion of elderly and intellectually impaired patients at the Littlemore did not compromise the ability of the hospital to accept voluntary admissions, following the Mental Treatment Act of 1930. This was because the hospital was in the unusual position of not suffering from overcrowding, a factor Dr Good attributed to the existence of the outpatient department. In 1934, 35% of patient admissions were voluntary and in 1938, Good reported that there had been a 60% increase in numbers of patients admitted on a voluntary basis compared with the preceding year.¹²⁶ How occupations were allocated between the acute, curable patients, the intellectually impaired and senile patients is not discussed. It might be assumed, however, that the normal work of the hospital (cleaning, work in the kitchens, gardening, etc.) was carried out by the intellectually impaired; calm, chronic patients; and convalescents, while OT-type activities (knitting, sewing, raffia work) were aimed at acute cases and the “deteriorated” chronic cases, including the more capable elderly patients.

The BoC was clear that occupations were for the benefit of patients and that any benefits to the hospital were incidental. That said, the goods produced as a result of the occupational therapy scheme that were not used within the Littlemore hospital were sold to the public at an annual Sale of Work, usually held just before Christmas. The sale held in 1933 attracted over 2,000 people to the hospital. Good declared that “the results were highly satisfactory”.¹²⁷ The range of crafts diversified over the years and by 1938, patients were reported as having been engaged in “fretwork, rug-making, knitting, elementary weaving and needlework of various kinds”.¹²⁸ Proceeds from the sale of goods were paid into the Patients’ Benevolent Fund, which was used to purchase all the materials used by the OT department. The MS was keen to emphasise that while OT did not generate a profit for the institution, “it does not make any charge upon Maintenance but is quite self-supporting”.¹²⁹ Its purpose was to benefit patients, rather than the institution.

¹²⁶ MS Report, LARs, 1934/5, 11; 1938/9, 13.

¹²⁷ MS Report, LARs, 1933/4, 8.

¹²⁸ BoC Report, LARs, 1938/9, 23.

¹²⁹ MS Report, LARs 1938/9, 7.

6.7 Patients and the Allocation of Occupation

Whether a patient was prescribed work, or OT, was affected by their mental condition (that is, their status as an acute or chronic case, and the nature of their mental disorder within those broad categories), their physical health, their age, and their class and gender. These factors were similar to those affecting the prescription of occupation in metropolitan institutions. At the Littlemore, acute patients and some patients with chronic conditions who were unable or unwilling to perform work around the hospital, such as dementia patients, were prescribed occupation. At the ADLS, work remained restricted to incurable, chronic and convalescent patients.

6.7.1 Mental Condition

In 1935, the CMO of the ADLS, Dr Christy, identified two main categories of patients. The first included those who were intellectually impaired (*les infirmes du cerveau*) and had been so since birth, or on account of illness or injury, and were regarded as incurable. The second were those who had an “evolving cerebral illness” which was considered curable, either

Table 36a: This table shows the mental condition ascribed to ADSL patients resident in 1921, 1927 and 1931.

	1921 M	1921 F	1921 T	1927 M	1927 W	1927 T	1931 M	1931 W	1931 T
Mania/melancholia/ delusions of persecution	54 = 27%	239 = 57%	293	57	253 = 56%	310	57 = 19%	267 = 54%	324
Epilepsy	14	16	30	26	15	41	29	19	48
Degeneracy – without alcoholic antecedents	25 = 13%	64 = 15%	89	36 = 12%	67 = 15%	103	36 = 12%	87 = 18%	123
Degeneracy – with alcoholic antecedents	30 = 15%	24	54	36 = 12%	36 = 8%	92	63 = 21%	33 = 7%	96
Acute or chronic alcoholism	26 = 13%	8	34	31 = 11%	3	34	21 = 7%	3	24
GPI	6 = 3%	7 = 2%	13	8 = 3%	3 = <1%	11	4 = 1%	1	5
Senile dementia	3	14 = 3%	17	2	17 = 4%	19	2	13 = 3%	15
Idiocy/cretinism/ Imbecility	32 = 16%	33 = 8%	65	53 = 18%	44 = 10%	97	72 = 24%	58 = 12%	130
Other forms of mental disorder	8	11	19	20	15	35	21 = 7%	13 = 3%	34
TOTALS	198	416	614	289	453	742	305	494	799

completely or partially.¹³⁰ It was not always clear from the annual medical reports, however, which conditions ascribed to patients were considered curable, as in the case of “degeneracy” and “chronic alcoholism”. Dr Christy highlighted in 1937 that although few cases of “degeneracy” were being discharged, not all were incurable and that many more would be curable if identified and treated earlier, and if more staff were at his disposal to treat them.¹³¹ The categories of “mental debility”, “idiocy”, “cretinism” and “imbecility” were evidently incurable conditions associated with intellectual impairment. Intellectual impairment was attributed to 16% of male residents in 1921 and 24% in 1931 (see Table 36 above).

Table 36b: This table shows the mental condition ascribed to pauper patients admitted to the ADLS in 1921, 1927, 1931.

	1921 M	1921 F	1921 T	1927 M	1927 W	1927 T	1931 M	1931 W	1931 T
Mania/melancholia/persecution	8 = 23%	18 = 38%	26 = 32%	2	10 = 37%	12 = 25%	1	14 = 37%	15
Epilepsy	4 = 11%	2	6 = 7%	0	0	0	3	1	4
Degeneracy – related to alcoholism	4 = 11%	2	6 = 7%	5 = 24%	5 = 18%	10 = 21%	2	10 = 26%	12 = 16%
Degeneracy – not related to alcoholism	4 = 11%	9 = 19%	13 = 16%	-	2	2	5 = 22%	1	6 = 8%
Acute or chronic alcoholism	4 = 11%	1	5	5 = 24%	1	6 = 13%	1	0	1
GPI	4 = 11%	3	7	2	1	3	4 = 17%	0	4
Senile dementia	2 = 6%	4 = 9%	6 = 7%	1	2	3	1	4	5
Idiocy/cretinism/imbecility	3 = 9%	6 = 13%	9 = 11%	5 = 24%	2	7 = 15%	4 = 17%	5 = 13%	9 = 12%
Other forms of mental disorder	2 = 6%	2	4	1	4 = 15%	5	2	3	5
TOTALS	35	47	82	21	27	48	23	38	76

Table 36c: This table shows the mental condition ascribed to paying patients admitted to the ADLS in 1921, 1927, 1931.

	1921 M	1921 F	1921 T	1927 M	1927 W	1927 T	1931 M	1931 W	1931 T
Mania/melancholia/persecution	4	17 = 71%	21	5	21 = 54%	26	3	23 = 61%	26 = 46%
Epilepsy	0	0	0	0	0	0	0	0	0

¹³⁰ Rapport du Médecin en Chef, ADLS, 1935, 7.

¹³¹ Rapport du Médecin en Chef, ADLS, 1937, 12-13.

Degeneracy – related to alcoholism	2	3	5	4	3	7	1	4	5 = 9%
Degeneracy – not related to alcoholism	2	3	5	3	5	8	6	5	11 = 19%
Acute or chronic alcoholism	4	0	4	4	0	4	1	0	1
GPI	5 = 19%	0	5	2	1	3	0	1	1
Senile dementia	6 = 22%	1	7	1	3	4	3	1	4 = 7%
Idiocy/cretinism/ imbecility	1	0	1 = 2%	0	0	0	2	2	4 = 7%
Other forms of mental disorder	3	0	3	1	6	7	3	2	5 = 9%
TOTALS	27	24	51	20	39	59	19	38	57

The admissions records (which differentiated between pauper and private patients) suggest that significantly more pauper than private patients suffered from intellectual impairment (between 11% and 15% of pauper patients, compared to between 2% and 9% of private patients admitted in 1921-1931) [see Tables 37 and 38 below]. The CMO reported in 1937 that a significant number of intellectually impaired patients had been admitted, for whom the only treatment was re-education through the discipline of work.¹³² Christy had been critical in 1935, however, of the “exaggerated claims” of certain “Germanic methods” of work therapy which had been greeted with scepticism by many French psychiatrists, including himself, who sought realistic, concrete objectives and not just words.¹³³ He must have been referring to MAT.

At the ADLS, those diagnosed with mania, melancholia and delusions of persecution or paranoia, accounted for 57% of all female residents in 1921 and 54% in 1931. From the admissions data, it appears that the category of mania, melancholia and delusions of persecution was particularly common amongst the female private patients. The condition was ascribed to 54%-71% of female private patients between 1921 and 1931, while to just 37%-38% of female pauper patients [see Tables 37 and 38 below]. Although Hermann Simon advocated work for such conditions, including mania, his methods were not adopted at the ADLS and it is impossible to ascertain whether these patients were prescribed work.

¹³² Rapport du Médecin en Chef, ADLS, 1937, 11.

¹³³ Rapport du Médecin en Chef, ADLS, 1935, 7.

Mental disorders associated with alcoholism were prevalent amongst male patients, and degeneracy (either associated with alcoholism or not) was also a significant category. Work was recognised as an effective treatment for alcoholism, so these patients would probably have been prescribed work. GPI was not a significant category amongst ADLS patients, affecting just 1% to 3% of male patients resident between 1921 and 1931, and an even smaller percentage of female patients. Nevertheless, it was a fatal condition before the (relatively late) introduction of malaria therapy at the ADLS in 1933.¹³⁴ Before this date, GPI was the attributed cause of death in 26% of the male patients who died in 1921, 21% of male deaths in 1927 and 24% in 1931 [see Table 39a below]. By 1937 GPI did not feature as a cause of death in the records [see Table 39b below].¹³⁵ It can be assumed that GPI patients would not have been capable of work before 1933, but thereafter, successful malaria treatment may have enabled convalescent patients, or those in remission, to work.

Table 37: This table shows the causes of death of male and female ADLS patients in 1921, 1927 and 1931:

	1921 – M	1921 – F	1927 – M	1927 – F	1931 – M	1931 – F
Neurological causes:	14 = 52%	9 = 39%	7 = 37%	13 = 33%	13 = 62%	12 = 28%
GPI	7 = 26%	2	2	1	5 = 24%	0
Respiratory causes	3 = 11%	5 = 22%	4 = 21%	11 = 28%	2	12 = 28%
Tuberculosis	1 = 4%	1	3 = 10%	6 = 15%	1	10 = 23%
Circulatory causes	1	3 = 13%	1	5 = 13%	0	8 = 19%
Digestive causes	3 = 11%	1	2	2	2	3
Genito-urinary causes	2 = 8%	3 = 13%	0	4	0	2
General/other causes	1	0	2	2	4	6
TOTALS	27	23	19	39	21	43

Table 38: This table shows causes of death amongst male and female ADLS patient in 1937 (when different categories were used):

Cause	Men	Women	Total
Dementia	4 = 17%	7 = 16%	11 = 16%
Heart condition	6 = 25%	12 = 27%	18 = 26%
Tuberculosis	2 = 8%	6 = 14%	8 = 12%
Acute lung condition	2 = 8%	7 = 16%	9 = 13%
Cerebral apoplexy	4 = 17%	5 = 11%	9 = 13%
Senility	1	2	3
Epileptic seizure	3 = 13%	-	3
Cancer	-	1	1

¹³⁴ Rapport du Médecin en Chef, ADLS, 1933 [no page nos.].

¹³⁵ Rapport du Médecin en Chef, ADLS, 1937, 23.

Acute delirium	-	2	2
Psycho-polyneuropathy	1	-	1
Urinary condition	1	1	2
Suicide	-	1	1
TOTALS	24	44	68

Although the Littlemore cared for both acute and chronic cases, Dr Good did not regard a mental hospital as an appropriate locus of care for the intellectually impaired, who comprised a growing proportion of admissions to the Littlemore each year. These patients could not benefit from the expensive treatment offered at a modern psychiatric hospital.¹³⁶ He acknowledged, however, the “extreme difficulty of obtaining vacancies for this class of case among the feeble-minded institutions in this country which are now practically full”.¹³⁷ In 1927, Good highlighted the number of “mental defectives” who had been admitted, and in 1930 he noted that the proportion of individuals suffering from “organic physical diseases and congenital mental defect” had increased.¹³⁸ The Board of Control inspectors also noticed the large number of “mental defectives” they encountered on their visit to the Littlemore in 1931 whom they felt would be better placed in a colony.¹³⁹ In 1932, the MS noted that there were 77 intellectually impaired male patients and 84 females in residence.¹⁴⁰ This was both costly for the local authority, and, “owing to their habits [the intellectually impaired] are detrimental to the acute cases”.¹⁴¹ “Occupational training”, Good observed, was of “great value in constantly employing many feeble-minded patients who [were] otherwise mischievous and troublesome”.¹⁴² This suggests that many of the Littlemore’s intellectually impaired patients would have been given some sort of work or occupation, if only to keep them out of mischief.

Senile dementia was suffered by a significant proportion of new patients (between 15% and 21%) [see Table 39 below]. This is in keeping with Good’s comments regarding the high proportion of elderly admissions. Patients suffering from senile dementia would have been unlikely to work but they may have benefited from some form of OT. ‘Confusion’ was also a

¹³⁶ MS Report, LARs 1925/6, 10; 1932/3, 9.

¹³⁷ MS Report, LARs, 1925/6, 10.

¹³⁸ MS Report, LARs, 1927/8, 8-9; MS Report, LARs, 1930/1, 9.

¹³⁹ BoC Report, LARs, 1931/2, 17.

¹⁴⁰ MS Report, LARs, 1932/3, 9.

¹⁴¹ Littlemore Annual Report 1932-3, 9.

¹⁴² MS Report, LARs, 1927/8, 9.

significant category (23% - 41%), but it is not clear whether this condition would have prevented patients from working or being occupied in some way. GPI was also an important category amongst the male patients; work would not have been appropriate for GPI patients until malaria therapy had been introduced. Dr Good's 1926/7 report mentions that research was being conducted into malaria therapy as a treatment for both encephalitis and GPI, although he does not refer to the results or whether patients were able to work after treatment.¹⁴³ Dr Armstrong reported in 1938/9 that malaria therapy was being continued with some successful results, but again, he did not mention patients' ability to work following treatment.¹⁴⁴ The fact that an ability to work was not mentioned suggests that it was not such a priority as in France.

The numbers of acute cases, or patients exhibiting the first signs of mental disorder, admitted to the Littlemore gradually increased after the Mental Treatment Act of 1930 was applied. Voluntary admissions grew from seven patients in 1931 to 47 in 1935 and 91 in 1939 [see Table 26, pages 208-9]. These acute patients would have been unlikely to be given work at the beginning of their illness but may have been engaged in craft activities on the wards after an initial rest period. They were likely to have worked, or to have continued with OT during convalescence, prior to discharge, like patients at the Maudsley. Between 50% and 100% of these voluntary patients were discharged within the same year of admission. This should have had the effect of increasing the annual rate of recovery or improvement, particularly towards the end of the 1930s when the proportion of voluntary admissions was c.30% of all admissions [see Table 40 below]. There was no significant change, however, probably because of the increasing number of incurable and elderly patients who were accumulating in the hospital. This is indicated by the increase in the number of patients who were discharged "not improved" (presumably to an alternative institution) from an average of 14 patients per year before 1931 to an average of 30 patients 1932-9 [see Table LM-1 in the Appendices].

¹⁴³ MS Report, LARs, 1926/7, 11.

¹⁴⁴ MS Report, LARs, 1938/9, 15.

Table 39: This table shows the ascribed forms of mental illness on admission (for the first time) to the Littlemore between 1924 and 1933:

Form of mental illness	Diagnosis on Admission 1924-28: Male	Diagnosis on Admission 1924-28: Female	Diagnosis on Admission 1929-33: Male	Diagnosis on Admission 1929-33: Female
Intellectual – with epilepsy	15	12	13	15
Intellectual – without epilepsy	17 = 7%	29 = 8%	17 = 6%	23 = 6%
Intellectual – moral	-	1	1	-
Insanity with epilepsy	8	3	1	3
GPI	25 = 11%	7	25 = 9%	7
Insanity with grosser brain lesions	1	1	5	-
Acute delirium	3	8	1	2
Confusion	72 = 32%	146 = 40%	66 = 23%	156 = 41%
Stupor	2	4	1	10
Primary Dementia / Schizophrenia	11	17	15	5
Recent mania	3	9	15	14
Chronic mania	-	-	1	4
Recurrent mania	6	-	8	4
Recent melancholia	10 = 4%	12 = 3%	40 = 14%	26 = 7%
Chronic melancholia	1	-	-	5
Recurrent melancholia	-	3	6	9
Alternating insanity	1	-	-	-
Delusional – systematised	1	5	2	2
Delusional – non-systematised	9 = 4%	13 = 4%	13 = 5%	27 = 7%
Volitional – impulse	2	5	2	1
Volitional – obsession	1	3	-	-
Volitional – doubt	1	5	2	1
Senile dementia	33 = 15%	75 = 21%	50 = 17%	55 = 15%
Secondary dementia	5	6	2	7
TOTALS	227	364	286	379

Table 40: This table shows rates of cure (recovery) and improvement ('relieved') at the Littlemore, indicating that these rates did not improve significantly following the Mental Treatment Act of 1930 which made provision for the admission of voluntary patients:

	1923	1924	1925	1926	1927	1928
Present on 1 Jan (M:F)	552 (223:329)	602 (276:326)	606 (266:340)	667 (222:445)	707 (254:453)	729 (268:461)
Admissions during year	182 (104:78)	156 (52:104)	245 (62:183)	182 (77:105)	146 (57:89)	142 (54:88)
Recoveries (M:F)	73 = 40% (29:44)	70 = 12% (25:45)	44 = 7.3% (23:21)	26 = 14% (8:18)	14 = 2% (7:7)	37 = 26% (15:22)
Relieved (M:F)	5 = 1% (2:3)	24 = 4% (11:13)	46 = 7.5% (14:32)	43 = 6.4% (11:31)	48 = 6.8% (14:34)	27 = 3.7% (10:17)

	1929	1930	1931	1932	1933	1934
Present on 1 Jan (M:F)	743 (273:470)	735 (282:453)	787 (295:492)	786 (285:501)	805 (299:506)	798 (296:502)
Admissions during year (M:F)	148 (70:78)	194 (66:128)	130 (55:75)	176 (78:98)	217 (88:129)	200 (79:121)
Recoveries (M:F)	32 = 22% (17:15)	20 = 2.7% (12:8)	17 = 2.2% (10:7)	22 = 13% (14:8)	30 = 14% (13:17)	30 = 15% (15:15)
Relieved (M:F)	52 = 7% (12:40)	47 = 6.4% (11:36)	36 = 4.6% (8:28)	59 = 7.5% (22:37)	68 = 8.4% (26:42)	66 = 8.3% (21:45)

	1935	1936	1937	1938	1939
Present on 1 Jan (M:F)	809 (299:510)	828 (301:527)	865 (321:544)	878 (329:549)	891 (333:558)
Admissions during year (M:F)	203 (82:121)	232 (110:122)	225 (88:137)	213 (83:130)	230 (89:141)
Recoveries (M:F)	29 = 14% (13:16)	33 = 14% (21:12)	63 = 28% (21:42)	61 = 29% (22:39)	63 = 27% (32:31)
Relieved (M:F)	60 = 7.4% (30:30)	69 = 8.3% (25:44)	46 = 5.3% (23:23)	43 = 5% (15:28)	51 = 5.7% (13:38)

6.7.2 Physical Health

Just as patients at the very beginning of their illness would not have been expected to work, so those in a weak physical condition would have been exempt. Many Littlemore patients were admitted in a poor physical state, leading Dr Good to comment that “so many of the admissions now are found to be suffering from severe physical illness and quite incapable of

being employed in any hard or continuous occupation”.¹⁴⁵ This may have been due to the number of frail, elderly admissions, or to the fact that there was a minor epidemic of influenza in 1927. Oxford was not severely affected by the General Strike of 1926, but the latter caused prices to rise, resulting in hardship for some.¹⁴⁶ The incidence of tuberculosis at the Littlemore was higher than the average for English mental hospitals. This often fatal disease was “overwhelmingly a scourge of the labouring poor”.¹⁴⁷ In 1929, the BoC inspectors noted that the average number of notifications of new cases of tuberculosis for all mental hospitals was 8.5 per thousand, while for the Littlemore it was 27.4 per thousand.¹⁴⁸ Deaths from the disease were 12.3 per thousand at the Littlemore, compared with the average of 6.9 for all mental hospitals.¹⁴⁹ Pneumonia, heart and kidney disease and “organic brain disease” were other major causes of death among patients. Littlemore patients were also subject to epidemics of encephalitis (1924-5) and German measles (1934) and regular outbreaks of influenza.¹⁵⁰ All these conditions would also have weakened patients and compromised their ability to perform work around the hospital, but they may have been given OT.

As indicated in the Medical Report of 1927, many ADLS patients suffered from physical conditions unrelated to their mental disorders. These varied but included migraines, rheumatism, digestive problems such as diarrhoea and vomiting, respiratory conditions including tuberculosis, pneumonia, bronchitis, laryngitis and influenza, heart problems and lumbago.¹⁵¹ The most common, the CMO maintained, were “always” those involving the digestive tract.¹⁵² In 1927, 214 men and 327 women suffered from one or more of these physical complaints. 282 patients required some sort of surgery, such as setting a fractured bone, tooth extraction and treating an abscess.¹⁵³ These conditions indicate the poor health of many patients, which may have prevented them from working. Tuberculosis, for example, was responsible for between 15% and 23% of female deaths between 1927 and 1931 [see

¹⁴⁵ MS Report, LARs, 1926/7, 12.

¹⁴⁶ Phyl Surman, *An Oxford Childhood: Pride of the Morning* (Stroud: The History Press, 1992), 39-40.

¹⁴⁷ F. B. Smith, *The Retreat of Tuberculosis, 1850-1950* (London: Croom Helm, 1988), 20.

¹⁴⁸ BoC Report, LARs, 1930/1, 15.

¹⁴⁹ Ibid.

¹⁵⁰ MS Report, LARs 1924/5, 8; 1934/5, 9.

¹⁵¹ Rapport Médical, ADLS, 1927, 25.

¹⁵² Ibid., 27.

¹⁵³ Ibid., 29.

Table 37, above]. In some cases, physical and mental conditions were linked, such as in the case of circulatory problems leading to the onset of senile dementia, as highlighted by the CMO in 1937.¹⁵⁴ Circulatory problems were particularly prevalent amongst female patients, accounting for 19% of female deaths in 1931 and 27% in 1937 [see Table 37 and 38, above]. Again, these conditions would have compromised a patient's ability to work.

6.7.3 Patient Age

Age, as well as mental and physical health, also influenced whether patients were ascribed work. The numbers of young men aged under 35 years (and therefore of working age) being admitted to the Littlemore had fallen from 18 in 1923 to 12 in 1925.¹⁵⁵ Dr Good attributed the decrease in admissions of the under-35s to the successful early treatment of younger patients at the outpatient clinic.¹⁵⁶ The numbers of young people being admitted to the Littlemore continued to fall, leading Dr Good to observe in 1935 that younger people tended to present themselves to the outpatient clinic more readily than the middle-aged.¹⁵⁷ This helped to prevent their being admitted to the hospital, but the result was an ageing hospital population, and a reduced number of capable patient workers.

In 1924, the average age on admission was 49 for men and 47 for women, but in the hospital at that time 59 males and 112 females were over the age of 60 years [see Table 41 below].¹⁵⁸ In 1926, 10 male and 26 female admissions were over 60 years; the average age of the men was 68 and that of the women 75 years.¹⁵⁹ The elderly, in Dr Good's view, should be looked after in Public Assistance Institutions or Infirmarys, and the intellectually impaired should be sent to specialist institutions, where they could receive appropriate care.¹⁶⁰ In 1927, 40% of patient deaths were attributed to "senile decay".¹⁶¹ The BoC noted in 1933 that 163 (or 28.6% of the total hospital population chargeable to the Oxford City and Oxford County local authorities) of the Littlemore's patients were over 60.¹⁶² By 1936, 191

¹⁵⁴ Rapport du Médecin en Chef, ADLS, 1937, 12.

¹⁵⁵ MS Report, LARs, 1925/6, 9.

¹⁵⁶ Ibid.

¹⁵⁷ MS Report, LARs, 1935/6, 9.

¹⁵⁸ MS Report, LARs, 1924/5, 9.

¹⁵⁹ MS Report, LARs, 1926/7, 8.

¹⁶⁰ MS Report, LARs, 1924/5, 9.

¹⁶¹ MS Report, LARs, 1927/8, 9.

¹⁶² BoC Report, LARs, 1933/4, 16.

patients were over 65 years, most of whom were suffering from “gross organic disease”.¹⁶³ The same year, eight patients aged over 75 years were admitted, few of whom required “the skilled nursing and medical care of an up-to-date mental hospital”.¹⁶⁴ During 1937, another 17 men and 26 women over 65 were admitted, comprising 23% of admissions.¹⁶⁵ While these patients were clearly unable to perform useful work, they may have benefited from occupational therapy provided by the nurses on the wards.

Table 41: This table shows the numbers of Littlemore patients who were intellectually impaired, over 60 or 65, or under 35 on admission:

Year	Intellectually Impaired	Over 60	Over 65	Under 35
1923 (M:F)	15 (7:8)	102 (51:51)		7 (5:2)
1924	32 (13:19)	110 (46:66)		7 (2:5)
1925	29 (7:22)	125 (46:79)		16 (4:12)
1926		36 (10:26)		
1928	17% males 20% females			
1930	23% males 13% females	52% men 21% women		13 (3:10)
1936			36 (13:23) Inc. 8 over 75	
1937			22.6%	

A high proportion of elderly, particularly female, former workhouse inmates could be explained in part by the government’s policy of encouraging the employment of younger workers, exposing many older people to unemployment and poverty.¹⁶⁶ Employers’ reluctance to employ women over 55 on account of their alleged poor health led to older women being particularly vulnerable to pauperism. Many women gave up work early to care for elderly relatives and afterwards found themselves unable to re-join the labour market.¹⁶⁷ For these destitute older people, the only option during the interwar period was the

¹⁶³ MS Report, LARs, 1932/3, 9; and 1936/7, 9.

¹⁶⁴ MS Report, LARs, 1936/7, 9.

¹⁶⁵ MS Report LARs, 1937-8, 11.

¹⁶⁶ Pat Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford and New York: Oxford University Press, 2000), 283.

¹⁶⁷ *Ibid.*, 284-5.

workhouse until 1929, and thereafter Public Assistance Institutions.¹⁶⁸ If the latter were overcrowded, or if the older inmates were mentally disordered, they might be transferred to the local mental hospital. In the 1930s, the old were the largest group of inmates of Public Assistance Institutions.¹⁶⁹

The profile of patients at the ADLS was also gradually ageing. In 1921 and 1927, 26% of male patients were aged 35-44 years; by 1931 the percentage had fallen to 20%. The proportion of male patients aged 45-54 years was 21% in 1921, and 25% in 1927 and 1931. The proportion of males aged 55-64 increased from 9% in 1921 to 17% in 1931. Amongst the female patients, the proportion of women aged 25-34 years fell from 9% in 1921 to 3% in 1931, while the proportion aged 55-64 increased from 20% in 1921 to 25% in 1931. There was a greater proportion of women in the older age groups, with only 17% of males aged 55-64 in 1931. In terms of age on admission, the data from 1937 shows that one quarter of male admissions were aged 35-44, while the largest age category for female admissions was 45-54 (23%). However, the 1937 breakdown also showed that 30% of male admissions were over 65 years, compared with 24% of female admissions. Whilst patients of over 65 were unlikely to work, those aged between 15 and 55 would have been expected to do so, their mental and physical conditions permitting.

Table 42: This table shows the ages of male and female patients (both pauper and paying) resident at the ADLS in 1921, 1927 and 1931, and admitted (table below) in 1937:

Age group in years	1921 – M Resident	1921 – F Resident	1927 – M Resident	1927 – F Resident	1931 – M Resident	1931 – F Resident	
Under 15	0	0	0	4	0	0	
15-19	12	14	9	8	8	7	
20-24	10	15	14	13	24	10	
25-34	34 = 17%	37 = 9%	36 = 12%	45 = 10%	48 = 16%	66 = 3%	
35-44	52 = 26%	98 = 24%	74 = 26%	79 = 17%	62 = 20%	80 = 16%	
45-54	42 = 21%	99 = 24%	72 = 25%	130 = 29%	77 = 25%	117 = 24%	
55-64	18 = 9%	84 = 20%	52 = 18%	92 = 20%	53 = 17%	123 = 25%	
65-70	14	41	18	32	15	35	
Over 70	6 = 3%	28 = 7%	14 = 5%	50 = 11%	18	56	
TOTALS	198	416	289	453	305	494	

¹⁶⁸ Ibid., 173.

¹⁶⁹ M. A. Crowther, *The Workhouse System, 1834-1929: The History of an English Institution* (London: Routledge, 1983), 111.

Age group in years	1937 – M New admissions	1937 – F New admissions
Under 15	3	1
15-19	8	3
20-24	4	10
25-34	21 = 26%	14 = 16%
35-44	11 = 13%	21 = 23%
45-54	11 = 13%	17 = 19%
55-64	9	12
65-70	14 = 17%	12 = 13%
Over 70	11 = 13%	10 = 11%
TOTALS	82	90

An explanation for the decreasing percentages of patient workers of both sexes and classes might lie in the increasing age of the patient population. The percentage of male pauper patients of working age decreased from 63% in 1925 to 49% in 1937, of female pauper patients from 58% to 51%, of male private patients from 32% in 1925 to 18% in 1937 and of female private patients from 23% in 1921 to 17% in 1937 [see Table 42, above]. The patient workforce was gradually contracting as older patients became too frail to work. The lack of movement in the patient population (that is, very few discharges as a result of cure or improvement) meant that new, potentially younger, patients were not being admitted in sufficient numbers to take the place of “retired” patients. The experience at the ADLS was therefore similar to that of the Littlemore in terms of the ageing patient profile and the diminishing numbers of patient workers. But at the Littlemore, there was less importance attached to the contribution made by patient work. Although produce from the hospital farm continued to be evaluated, the precise numbers of working patients were no longer recorded and the priority in terms of patient occupation was on the provision of OT. Whilst old age was clearly a barrier to patient work, if not OT, class was also a divisive factor between those who worked and those who did not.

6.7.4 Class and Gender

The ADLS provided care for both private patients who were able to pay for their care, and pauper patients. In 1919, the proportion of private patients was 27%, but this figure decreased to 25% in 1928 and 19% by 1939 [see Table 44, below]. There were many more

female than male private patients; 71% of private patients were female in 1919, although this figure decreased to 58% in 1939 [see Table 46, below]. Private patients were divided into four classes. Patients in class four comprised an average of 50% of the private patients [see Table 43, below]. Although there is no evidence to support this, it is plausible to assume that the top three classes of patients, some of whom had their own personal servants in the asylum, would not have been expected to work, due to their middle-class status. 18% - 33% of male private patients worked [see Table 32 page 232], compared with 46% - 63% of male pauper patients [Table 31 page 231]. It is likely that most of the working private patients belonged to the fourth tier of private patients, whose relatives were charged roughly the same as the department was paying to maintain pauper patients, and who shared the same daily regime as the pauper patients. In 1927, 40% of male private patients, and only 39% of male pauper patients, worked. This unusual situation was not remarked upon in the annual report, but it happened to coincide with an epidemic of influenza that badly affected the asylum.¹⁷⁰

Table 43: This table shows the class divisions, based on average number of patients resident per year, of patients at the ADLS:

	1919	1922	1925	1928	1931	1934	1936	1939
All Paying Patients (male: female)	167	127	173	188	198	219	215	175
1 st class (male: female)	20 3:17	14 2:12	23 6:17	24 (4: 20)	27 3:24	28 5:23	33 9:24	31 12:19
2 nd class (male: female)	27 5:22	14 5:9	18 7:11	35 (19: 16)	37 25:12	43 30:13	34 25:9	26 12:14
3 rd class (male: female)	38 12:26	24 6:18	33 10:23	38 (15: 23)	31 6:25	34 9:25	31 9:22	33 17:16
4 th class (male: female)	82 29:53	75 20:55	99 37:62	91 (31: 60)	103 31:72	114 35:79	117 34:83	85 32:53
All Pauper Patients (male: female)	442 159:283	491 168:323	519 187:332	573 (220:353)	598 237:361	624 269:355	639 261:378	743 316:427
Average total	609	618	692	761	796	843	854	918

Table 44: This table shows the proportion of paying to pauper patients at the ADLS, based on the average annual population:

	Total Average Population	Pauper Patients	% Pauper	Paying Patients	% Paying
1919	609	442	73%	167	27%
1922	618	491	79%	127	21%

¹⁷⁰ Rapport Médical, ADLS, 1927, 33.

1925	692	519	75%	173	25%
1928	761	573	75%	188	25%
1931	796	598	75%	198	25%
1934	843	624	74%	219	26%
1936	854	639	75%	215	25%
1939	918	743	81%	175	19%

There was more accommodation for female patients than male patients at the ADLS, although the proportion of male patients gradually increased from 32% in 1921 to 41% in 1939 [see Table 45]. This trend applied to both pauper and private patients [see Tables 46 and 47]. A higher percentage of male private patients worked than female private patients (an average of 26% of men and 18% of women, as indicated in Table 49). This might be explained by attitudes towards middle-class women, around whom a “cult of domesticity” had been created that emphasised middle-class women’s reproductive, maternal and homemaking activities.¹⁷¹ In contrast, an average of 54% of pauper women, and 51% of pauper men worked within the asylum [as shown by Table 48]. In other words, three times as many female pauper patients than their private counterparts worked, and twice as many male pauper patients than private patients, worked. Class and gender were therefore significant influences on the prescription of patient work in provincial France, despite its alleged therapeutic benefits for *all* classes and both genders. As in England, manual work was considered unsuitable for middle-class men, and the fact that patients were paying for their care meant that they were not expected to contribute to their maintenance costs with their labour. This was made explicit in the regulations of 1857.¹⁷²

Table 45: This table shows the numbers and proportions of male and female patients at the ADLS, both pauper and paying, based on average annual population figures.

	Average Population	Men Pauper:Paying	Total Men	% Men	Women Pauper:Paying	Total Women	% Women
1919	609	159 : 49	208	34%	283 : 118	401	66%
1922	618	168 : 33	201	33%	323 : 94	417	67%
1925	692	187 : 60	247	36%	332 : 113	445	64%
1928	761	220 : 69	289	38%	353 : 119	472	62%
1931	796	237 : 65	302	38%	361 : 133	494	62%
1934	843	269 : 79	348	41%	355 : 140	495	59%
1936	854	261 : 77	338	40%	378 : 138	516	60%
1939	918	316 : 73	389	42%	427 : 102	529	58%

¹⁷¹ Accampo, Fuchs, and Stewart, *Gender and the Politics of Social Reform*, 13.

¹⁷² Article 151, Bulletin Officiel du Ministère de l’Intérieur, Circulaire No. 7, 20/03/1857, 57.

Table 46: This table shows the proportion of male and female patients within the paying patient category:

	Average Paying Population	Paying Men	% Paying Men	Paying Women	% Paying Women
1919	167	49	29%	118	71%
1922	127	33	26%	94	74%
1925	173	60	35%	113	65%
1928	188	69	37%	119	63%
1931	198	65	33%	133	67%
1934	219	79	36%	140	64%
1936	215	77	36%	138	64%
1939	175	73	42%	102	58%

Table 47: This table shows the proportion of male and female patients with the pauper category at the ADLS:

	Average Pauper Population	Pauper Men	% Pauper Men	Pauper Women	% Pauper Women
1919	442	159	36%	283	64%
1922	491	168	34%	323	66%
1925	519	187	36%	332	64%
1928	573	220	38%	353	62%
1931	598	237	40%	361	60%
1934	624	269	43%	355	57%
1936	639	261	41%	378	59%
1939	743	316	43%	427	57%

Table 48: This table shows the number of male and female pauper patient workers, expressed as a proportion of total male and female pauper patient populations:

	All Pauper men	Pauper male workers	% working pauper men who worked	All Pauper women	Pauper female workers	% Pauper women who worked
1923	176	104	59%	334	193	58%
1925	187	119	63%	332	193	58%
1927	293	111	39%	345	182	53%
1929	225	103	46%	357	178	50%
1930	234	113	48%	359	179	50%
1932	242	117	48%	360	191	53%
1934	269	140	52%	355	199	56%
1936	261	140	54%	378	204	54%
1937	272	133	49%	389	199	51%

Table 49: This table shows the number of male and female paying patient workers, expressed as a proportion of total male and female paying patient populations:

	All Paying men	Paying male workers	% paying men who worked	All paying women	Paying female workers	% paying women who worked
1923	35	7	20%	96	22	23%
1925	60	19	32%	113	25	22%
1927	72	29	40%	116	19	16%
1929	66	22	33%	129	20	16%
1930	67	17	25%	131	21	16%
1932	57	17	30%	143	20	14%
1934	79	15	19%	140	28	20%
1936	77	16	21%	138	23	17%
1937	79	14	18%	123	21	17%

The Littlemore Hospital was a public asylum, catering for predominantly pauper patients. Patients were referred by one of the Oxfordshire Poor Law Unions, or by local authorities from outside Oxfordshire [see Table LM-3 in the Appendices]. The hospital was under contract with the London County Council to receive 20 patients per year, and with the Middlesex local authority (c.125 patients). These patients, as well as those coming to the Littlemore from Croydon, Nottingham, Buckinghamshire and East Ham, would have had quite different backgrounds to patients coming from rural Oxfordshire, but all were pauper patients. The only private patients were Service, or ex-Service, patients who were classed as “private” in order to avoid the stigma of certification. There were 20-23 such patients between 1923 and 1935 [see Table LM-3]. The issue of the suitability of work for middle-class patients therefore did not arise at the Littlemore.

The BoC inspectors noted in 1937 that although OT on the wards was well organised for the female patients, very little was being done for the men. The reason given by Dr Good, that many of the male patients came from rural areas where they were “not accustomed to hand-crafts”, was not accepted by the inspectors who felt that with some encouragement, many of the male patients from both urban and rural backgrounds, would benefit from “this form of employment”.¹⁷³ Presumably patients from rural backgrounds who were well

¹⁷³ BoC Report, LARs, 1936/7, 21.

enough to leave the wards would have had the opportunity to work outdoors, either working on the farm, in the gardens or the grounds. An increasing number of patients were admitted from Oxford City; in 1923, 13% of patients were from Oxford, while in 1935, the figure was 24% and in 1939, 26%.¹⁷⁴ This increase reflected the growing population of Oxford City as workers were attracted to its automotive industries, including many men from South Wales (although there no were Welsh amongst admissions to the Littlemore).¹⁷⁵ Whilst this influx of urban patients may have negated Good's argument regarding the unpopularity of craft-related activities with rural patients, there is no indication that the occupations provided at the Littlemore reflected the industrial profile of interwar Oxford. This underscores that a therapeutic rationale for occupation was prioritised over its rehabilitative function.

6.7.5 Rates of Cure

The percentage of cures and improvements over the total number of patients resident indicate that a large proportion of ADLS patients were incurable, or at least long-stay. Only 7% and 6% of the total number of patients treated were discharged as cured or improved in 1921 and 1927 respectively, figures that fell to 3% in 1931 and stood at 6% in 1937 [see Table 50 below]. The atypically low percentage of patients leaving cured or improved in 1931 may have been due to the economic crisis, rather than a particularly low recovery rate. Relatives may have been reluctant to reclaim their family members at a time of high unemployment and hardship, and the CMO may have felt that it was better to retain patients in the asylum as they were unlikely to find work after discharge. This was the experience in Paris during the economic crisis. The rate of 6-7% in other years does not suggest a great deal of patient movement; the death rate exceeded the rate of cure and improvement in many years [see Table 50 below]. Most patients who were discharged as cured or improved spent six months or less at the asylum. The others can be assumed to be long-stay patients for whom work would have been part of their daily routine.

¹⁷⁴ A full breakdown of the origins of Littlemore patients is given in Table LM-2 in the Appendices.

¹⁷⁵ R.C. Whiting, *The View from Cowley: The Impact Of industrialisation Upon Oxford, 1918-1939* (Oxford: Clarendon Press, 1983). There is no suggestion in the records that patients from South Wales were admitted to the Littlemore, but they could have been classified as coming from Oxford.

The rate of cure or improvement was higher at the Littlemore, where the rate was an average of 11% of the total number of patients treated in 1923-5; 7.5% in 1926-30 and 10% in 1933-9 (after the worst of the financial crisis, and after the passage of the Mental Treatment Act in 1930) [see Table 51 below]. In 1931-2 the rate fell to 6-7%, which could be explained by the economic crisis, as in France (see above). These rates of cure indicate a more dynamic environment (in the sense of patient movement) at the Littlemore than the ADLS, although the difference was not significant. In both establishments, whilst a few patients did make a recovery and leave the asylum, many stayed for long periods, thereby ensuring a potentially stable workforce of incurable patients. Of these, however, many were too frail and elderly to work, or too badly “deteriorated”. At the Littlemore, most of these patients and those at the acute stage of their illness would have been given OT on the wards (although the BoC noted that this was not always the case). At the ADLS it must be assumed that such patients remained unoccupied, since OT was not provided, leading to further deterioration of their condition. That said, there was another way of occupying patients within the institution that did not involve work or OT. As in the metropolitan institutions, patients were encouraged to participate in the organised entertainments programme, which had been a feature of asylum regimes since the days of moral therapy in the early nineteenth century.

Table 50: This table shows the numbers and percentages of patients (total, male, female) discharged from the ADLS whose symptoms were described as recovered or relieved.

Year	No. patients present on 1/1	No. patients discharged recovered or relieved	% discharged cured or improved
1921 – T	604	51	8%
1921 – M	195	24	12%
1921 – W	409	27	7%
1927 – T	757	49	6%
1927 – M	290	18	6%
1927 – W	467	31	7%
1931 – T	792	29	4%
1931 – M	298	10	3%
1931 – W	494	19	4%
1937 – T	869	65	7%
1937 – M	343	27	8%
1937 – W	526	38	7%

Table 51: This table shows the total number and percentage of patients discharged from the Littlemore whose symptoms were described as cured or improved.

Year	No. patients present on 1/1	No. patients discharged recovered or relieved	% discharged cured or improved
1923	552	78	14%
1924	602	94	16%
1925	606	90	15%
1926	667	69	10%
1927	707	62	9%
1928	729	64	9%
1929	743	84	11%
1930	735	67	9%
1931*	787	53	7%
1932	786	81	10%
1933	805	98	12%
1934	798	96	12%
1935	809	89	11%
1936	828	102	12%
1937	865	109	13%
1938	878	104	12%
1939	891	114	13%

* Mental Treatment Act 1930 came into operation

6.8 Entertainments

Before World War I, a programme of entertainments or *distractions* for patients had been itemised in the ADLS Director's reports. These had included picnics in the countryside, walks into town, concerts, fireworks to mark the 14 July and celebration of the Fête-Dieu, a Catholic celebration that took place 60 days after Easter. No such events were mentioned in the post-war reports. This is not to say that they did not occur (there are photographs of the Fête-Dieu taking place in 1960 at the ADLS), but they were not discussed in the annual reports. The links between an entertainments programme and the psychological approach of moral therapy may have discouraged CMOs from making this a priority, or perhaps there were simply insufficient staff to organise it. However, a budget for "distractions and games for patients" appeared in the asylum accounts for the first time in 1934, and continued to do so until 1939 (expenditure varied between 215F and 377F; see Table 52 below), indicating that entertainments were provided, at least from 1934 onwards. Before World War I, the emphasis had been on securing entertainment that did not incur any cost to the

asylum;¹⁷⁶ this policy may have continued until 1934. At the Littlemore, expenditure of between £33 and £125 per annum appeared in the hospital accounts between 1923 and 1932; thereafter no figures were given [see Table 53 below] but the programme continued to be discussed and added to by the MS.

Table 52: This table shows the amount spent on ‘distractions’ for patients and on the library at the ADLS, 1934-9 (such expenditure was not mentioned in the accounts in other years):

	1934	1935	1936	1937	1938	1939
Distractions	215F	272F	150F	377F	292F	617F
Library	641F	-	210F	299F	680F	290F

Table 53: This table shows the amount spent annually by the Littlemore Hospital on amusements for patients.

Year	Amount spent on amusements	Year	Amount spent on amusements
1923	£44 18s	1932	£98 5s
1925	£33 15s	1933	Not mentioned
1926	£79 17s	1934	Ditto
1927	£91 6s	1935	Ditto
1928	£63 12s	1936	Ditto
1929	£95 19s	1937	Ditto
1930	£125 14s	1938	Ditto
1931	£85 6s	1939	Ditto

At the Littlemore, references were made to the entertainments’ programme in the MS’s reports and in the BoC inspectors’ report. In 1925/6, for example, Dr Good observed that “various concerts have been held throughout the year by Staff, both male and female, for the amusement of patients”. He added that “dances have been held in the Entertainment Hall, and in many of the Wards”.¹⁷⁷ These events continued throughout the interwar period, as indicated by the reports of 1926/7¹⁷⁸ and 1937/8.¹⁷⁹ In 1926, “wireless” sets were provided in two of the largest wards, and also in the nurses’ quarters, and a cinematograph was installed in the Recreation Hall in 1928.¹⁸⁰ Sound apparatus for showing “talkie” films

¹⁷⁶ The cost of travelling on the tram to local beauty spots for picnics was deducted from the patients’ *pécule*, for example.

¹⁷⁷ MS Report, LARs, 1925/6, 11.

¹⁷⁸ MS Report, LARs, 1926/7, 10.

¹⁷⁹ MS Report, LARs, 1937/8, 10.

¹⁸⁰ MS Report, LARs, 1927/8, 10; and 1928/9, 9.

was introduced in 1934.¹⁸¹ Dr Armstrong (appointed in 1936) introduced the practice of sending groups of “the better type of working patients” for charabanc outings to some of the local beauty spots (another indication that patients were performing useful work). He noted that several of the older patients had not left the grounds for many years (despite the “open door” policy) and were very appreciative of this innovation.¹⁸² Dr Penton (the new assistant MO) introduced folk dancing classes in 1939 and organised concerts given by the patients.¹⁸³

Attempts were made at the Littlemore in 1937 to increase opportunities for outdoor exercise.¹⁸⁴ This measure coincided with the physical culture movement of the 1930s, celebrated at the Festival of Youth event in London in July 1937. The cultivation of a fit male body was seen as an obligation of citizenship and a patriotic duty.¹⁸⁵ Women were also encouraged to take up sporting, outdoor and physical activities during the interwar period.¹⁸⁶ Dr Armstrong introduced weekly keep fit classes at the Littlemore, conducted by an instructor from the Keep Fit movement, and classes in Physical Training were held regularly for both male and female patients.¹⁸⁷ Cricket and football teams of male patients were created and a schedule of both home and away matches was organised with patient teams from neighbouring hospitals.¹⁸⁸ Facilities for hockey and netball were provided for nurses and female patients, and badminton and tennis equipment was provided in some of the women’s gardens. Indoor recreational facilities included table-tennis and darts for the men and table-tennis and card games for the women.¹⁸⁹ Nurse B, who joined Littlemore in 1936, remembered an annual sports day, as well as a fancy-dress ball at Christmas.¹⁹⁰

The Littlemore’s Chaplain, whose role had involved the management of the library since the Littlemore’s establishment in 1847,¹⁹¹ was responsible for distributing books from the

¹⁸¹ BoC Report, LARs, 1934/5, 17.

¹⁸² Ibid.

¹⁸³ MS Report, LARs, 1939/40, 11.

¹⁸⁴ MS Report, LARs, 1938/9, 10.

¹⁸⁵ Ina Zweiniger-Bargielowska, “Building a British Superman: Physical Culture in Interwar Britain,” *Journal of Contemporary History* 41, no. 4 (2006): 596.

¹⁸⁶ Ibid., 602.

¹⁸⁷ MS Report, LARs, 1938/9, 10.

¹⁸⁸ Ibid.

¹⁸⁹ Ibid.

¹⁹⁰ Interview with former nurse, Littlemore History Project, Oral History Interview by J.Goddard (1994/5). OHA/LH/OT233.

¹⁹¹ Good, “History and Progress,” 603.

library to patients on the wards once a month. The Chaplain noted in 1924/5 and again in 1927/8 that a great many books had been damaged or destroyed, and that the library was in need of new ones.¹⁹² On hearing that books were being destroyed by patients, the BoC suggested that such wastage could be reduced by starting a bookbinding workshop (advice repeated in 1939), which might also provide an interesting and useful occupation for patients who were not otherwise employed.¹⁹³ This suggestion (although it does not appear to have been acted upon) indicates how institutional need influenced patient work opportunities. There was no mention of a library for patients in the ADLS reports. There was a budget for library expenses [see Table 52 above], but this may have been for a medical library.

Providing patients with entertainment, exercise and reading material was clearly a priority at the Littlemore. The allocation of staff time and money to organise the events indicated a concern for patient well-being on the one hand, and an appreciation of the psychological benefits of such activities on the other. The lack of a significant programme at the ADLS suggests both a lack of resources and a failure to appreciate the psychological benefits of distractions. The latter stemmed from an organicist interpretation of mental disorder, associated with French psychiatry's close alignment with neurology. A lack of resources, compared to those of the Littlemore, was also indicated by the difference in the material level of patient comfort experienced at the two institutions.

6.9 Facilities and Patient Comfort

Patient comfort at the ADLS was compromised by a lack of resources. Finances were limited to the provision of fundamental facilities such as central heating and electric lighting, which were installed in 1922 and 1923 respectively. Washbasins were provided in all sections in 1924 so patients no longer had to wash at the pump in the mornings.¹⁹⁴ Work to replace the existing "slopping out" buckets for the disposal of faeces with flushing water-closets began in 1929 and was completed in 1932.¹⁹⁵ The new CMO appointed in 1933, Dr Schutzenberger, was very critical of facilities at the ADLS. He was particularly appalled by the level of

¹⁹² MS Report, LARs, 1924/5, 6.

¹⁹³ BoC Report, LARs, 1933/4, 17.

¹⁹⁴ Rapport Médical, ADLS, 1924, 35-6.

¹⁹⁵ Rapport Médical, ADLS, 1929, 36; Rapport du Directeur, ADLS, 1932, 437.

overcrowding, which denied patients the regulated amounts of space or air cubage, and by the lack of baths.¹⁹⁶ This was not only problematic from the perspective of personal hygiene (an average of only 10 baths were taken per year per patient) but also from a therapeutic perspective. Agitated patients were missing out on hydrotherapy, which was a valuable means of soothing them.¹⁹⁷ He did not mention that OT or work might be substituted for hydrotherapy as a means of calming the agitated.

The financial crisis of 1931 limited expenditure on building maintenance and repairs and new works had to be postponed.¹⁹⁸ The AD remarked that “it has been difficult to get things done in the midst of an economic and social crisis, and more than one project has had to be cancelled in these difficult circumstances.”¹⁹⁹ Plans to extend the central heating system and modernise the kitchens (reportedly in a “dangerous” condition) were shelved.

Nonetheless, the AD maintained that they continued to try and make the hospital a more agreeable and happier place for the “*pauvres déshérités*” in their care. Patients could, by 1937, have weekly baths or showers, and the interiors had been repainted.²⁰⁰

At the Littlemore, standards of living for patients were superior to those of the ADLS. The patients’ quality of life, indicated by measures such as the decoration of the wards and communal spaces, a more varied diet and personalised clothing, gradually improved during the interwar period. The fact that some patients were allowed to stay up until 10pm was an unusual (at most mental hospitals patients retired at around 7.30pm) and welcome privilege.²⁰¹ The BoC noted that since women inspectors had been permitted to conduct “statutory visits” to mental hospitals, this had resulted in greater attention being paid to the clothing of female patients. “Greater variety in dress helps to lessen the monotony which is the bane of institutional life,” they maintained, “and is a step towards recovery when a patient can be induced to take some interest in her appearance”.²⁰² Following pressure from the BoC, “suitable” female patients at the Littlemore were able to choose the colour of the

¹⁹⁶ Rapport Médical, ADLS, 1933 [no page nos.].

¹⁹⁷ Ibid.

¹⁹⁸ Rapport du Directeur, ADLS, 1932, 435.

¹⁹⁹ Rapport du Directeur, ADLS, 1937, 8.

²⁰⁰ Ibid.; Rapport du Directeur, ADLS, 1938, 10.

²⁰¹ BoC Report, LARs 1923, 14.

²⁰² Nineteenth Annual Report of the BoC, 1932, 8.

dresses made for them and to have “clothing marked for their own personal use”.²⁰³ The women’s underclothing had shocked one nurse who joined the staff in 1936; she described the “calico drawstring drawers” as very old fashioned.²⁰⁴ The underwear was modernised in 1937, much to the BoC’s relief, and patients’ boots began to be fitted individually.²⁰⁵ Dentures “for the better types of patient” and glasses for those with defective vision were provided from 1937.²⁰⁶ A fish fryer was installed in the kitchen in 1938 so that fish and chips could be served once a week; a measure that was “much appreciated” by staff and patients.²⁰⁷ These measures indicate that attention was being paid to the general comfort of patients and to ways of making the hospital regime more bearable. This attitude complements the emphasis on therapeutic occupation (to benefit the patient) rather than productive work (to benefit the institution) and indicates the greater availability of resources at the Littlemore. Resources, and patient comfort, were scarce at the ADLS where patient work constituted an essential contribution to the asylum budget.

6.10 Work Outside the Asylum – Rehabilitation and Support

As well as making a significant financial contribution to institutional budgets (although at the Littlemore this contribution was not emphasised) and providing an important means of therapy (which was the priority at the Littlemore), patient work also fulfilled a rehabilitative function. An ability to work was considered one of the criteria for discharge at the ADLS, where a patient with no means of support (either by working or living with family) was to be retained (the phrase *à maintenir* appeared in their records).²⁰⁸ A patient who was working well in the asylum was deemed capable of doing so outside it. An ability to work was not a criterium for discharge at the Littlemore, where support for discharged patients was more readily available, but it was recognised that unemployment could lead to anxiety and possible relapse. Successful rehabilitation depended partly on whether the activities

²⁰³ BoC Report, LARs, 1936/7, 20.

²⁰⁴ Interview with former nurse, Littlemore History Project, Oral History Interview by J.Goddard (1994/5). OHA/LH/OT233.

²⁰⁵ Ibid.

²⁰⁶ MS Report, LAR 1937/8, 9.

²⁰⁷ MS Report, LARs, 1938/9, 9.

²⁰⁸ Guillemain, *Chronique De La Psychiatrie Ordinaire*, 45.

undertaken by patients in hospital prepared them for work in their local community, and partly on the availability of support from outside agencies.

6.10.1 The Relationship between Work Inside the Institution and in the Community

At the ADLS, categories of employment inside the asylum were identical to those used in the pre-war period. The tasks appeared to have been engineered to serve the needs of the asylum and had not evolved to prepare patients for changes in the local economy [see Tables AS-PW5/6]. Farming, however, as the second largest category of employment within the ADLS for men, after cleaning, was useful preparation for patients seeking work in the local community. Although the numbers employed in agriculture were declining in the department of La Sarthe (22,000 Sarthois agricultural workers left the countryside in 1922 alone), 67% of the population still lived in rural areas in 1936.²⁰⁹

The third largest category of male employment was work in the laundry, but, as in Paris, this was indicative of institutional need. The only type of work available in the asylum that represented a growth area in the local economy (metallurgy) was tin-plate-making, but this involved very few patients. Metallurgy flourished in Le Mans, with the opening of La Maison Chappée, a new foundry producing radiators, which serviced the growing motor industry in Le Mans. The latter employed 2,000 workers in 1920 and 17,000 in 1933.²¹⁰ Another firm involved in metalwork was Carel et Fouché, which produced metal construction materials for the railways. Le Mans' artisanal activities, such as shoe-making, saddlery, brickmaking, ceramics, and tanning were in decline while food processing prospered.²¹¹ It was the artisanal occupations, notably shoe-making, that employed patients within the ADLS.

For women, the largest employment categories were housework and sewing. Whilst textiles had been an important aspect of the local Sarthois economy in the past, this industry was in sharp decline during the interwar period. Needlework, however, alongside housework, ironing, knitting or working in the kitchen, were tasks with which women were familiar in a domestic context. So, whilst the work available to women was not representative of the changing local economic profile, nor of the expansion in the range of work opportunities for

²⁰⁹ André Lévy, ed. *La Sarthe Des Origines À Nos Jours* (Saint-Jean-d'Angély: Éditions Bordessoules, 1983), 343-4.

²¹⁰ Ibid., 344.

²¹¹ Ibid., 350.

women, it could be construed as rehabilitative for those returning to a domestic role, which was the role they were encouraged to pursue. The employment of female patients in the farmyard was also a useful and familiar task for those returning to work on the family small-holding.

At the Littlemore, the previous occupation assigned to the largest group of patients was labouring, which employed c.20% of male patients between 1926 and 1939 [see Table LM-12]. "Labouring" could be interpreted in a variety of ways, and it is unclear whether patients were agricultural labourers or workers on a building site. The building industry in Oxford was expanding, stimulated by the requirement for new housing, factories and extensions to the university colleges.²¹² Brickmaking at the Littlemore was therefore a useful skill to develop. Agriculture, on the other hand, was in sharp decline in Oxfordshire. Between 1921 and 1931, the percentage of agricultural workers in the county fell by 32%, compared to a fall of 17% nationally.²¹³ By 1931, just 6% of the nation's working population were involved in agriculture (compared to 36% in France).²¹⁴ Work on the hospital farm was not, therefore, particularly useful in terms of future employment prospects, but it was considered particularly therapeutic.

Between c.3% and 13% of Littlemore patients were engaged in factory work prior to admission. This was a rapidly growing sector in Oxford. As in Le Mans, car manufacture and metallurgy developed rapidly in Oxford during the interwar period. In 1923, Morris Motors employed 1,650 workers and by 1927 this number had grown to c.5,000.²¹⁵ Pressed Steel's workforce grew from 546 in 1926 to 5,250 in 1939. Morris Motors, Pressed Steel and Osberton Radiators between them employed 30% of Oxford's insured population in 1939.²¹⁶ There was no work within the Littlemore Hospital that would have prepared patients for this type of work, however. Between 4% and 9% of Littlemore patients were previously employed in traditional trades such shoe-making, carpentry, stone masonry and tailoring.

²¹² Eleanor Chance, "Modern Oxford," in *A History of the County of Oxfordshire*, ed. Alan Crossley and C.R. Elrington (London: British History Online, 1979). (Accessed 02/03/2019).

²¹³ Whiting, *The View from Cowley*, 39.

²¹⁴ Giovanni Federico, Stephen Broadberry, and Alexander Klein, "Sectoral Developments, 1870-1914," in *The Cambridge Economic History of Modern Europe*, ed. Stephen Broadberry and Kevin O'Rourke (Cambridge: Cambridge University Press, 2010), 210.

²¹⁵ Chance, "Modern Oxford."

²¹⁶ Ibid.

Although these artisanal activities were in decline in Oxford, they were still viable, so work within the hospital in these areas was rehabilitative. Domestic service was a large employer within Oxford due to the continued growth of the university. 23% of Oxford's workforce in 1931 were employed in domestic service, compared with the national average of 13%.²¹⁷ Between 4% and 14% of patients admitted to the Littlemore between 1926 and 1939 were employed in some form of service.²¹⁸ Work around the hospital, such as cleaning and helping in the kitchens or laundry, would have been useful preparation for this type of work. It is not clear whether Littlemore patients were offered any form of clerical work (as some patients were at the ADLS), but this was another expanding sector in Oxford. The numbers employed in local government and the civil service increased dramatically, from fewer than 500 in 1911 to over 2,700 in 1931.²¹⁹ Approximately 6% of patients admitted to the Littlemore in 1926, and 11% in 1937, held a clerical or business role [see footnote 218].

Some of the work offered to patients reflected the more traditional, long-established occupations of the local economy, such as carpentry, but there did not appear to have been any attempt to equip patients with the skills required to work in the new, expanding sectors, namely the automobile industry or metal working. The introduction of OT at the Littlemore offered a different type of occupation to patients, but arts and crafts were not representative of the new working environments. In fact, they represented a return to more traditional methods of working. Whilst institutional work and OT served to distract patients, and had a perceived therapeutic value, they could not be described as rehabilitative in the sense that they prepared patients for the interwar labour market. This was not important for those who were to remain in institutional care, for whom re-joining the labour market was unlikely to become an option. For the curable patients at the Littlemore and the ADLS, however, this was an anomaly given the emphasis placed by governments on productivity and the concern of doctors regarding recidivism amongst the unemployed. It would not be until the 1950s in England that "industrial therapy" was introduced to mental hospitals. This recreated a factory environment, enabling patients to become accustomed to working on an assembly line.²²⁰ Even if the work available within institutions was not particularly geared

²¹⁷ Ibid.

²¹⁸ Littlemore Hospital Admissions Book 1922-65 gives (partially complete) details of male patients' previous occupations. OHA/L7/A1/1/10.

²¹⁹ Chance, "Modern Oxford."

²²⁰ See: Long, "Rethinking Post-War Mental Health Care," 738-58.

towards the demands of the local labour market, support for recently discharged patients was augmented during the interwar period.

6.10.2 After-Care

In France, support for recovered patients was patchy outside the capital. When Dr Bourdin of the ADLS retired in 1931, he produced a list of changes that would need to take place if reforms to the law of 1838, discussed for so many years, were put into action, allowing a greater focus on acute patients. One of the points he made referred to the after-care of recently discharged patients. Bourdin emphasised the need to help find work for patients, who were often disorientated on leaving the asylum and unused to fending for themselves. Bourdin noted that Patronage Societies existed in some departments, such as the Seine and the Rhône, but he had experienced a lack of support for such an initiative in La Sarthe, which he attributed to a lack of trust amongst the locals in the asylum system.²²¹ Bourdin's replacement, Dr Schultzenberger, was able to persuade the Prefecture to establish a Patronage Society in 1933.²²² In terms of support of after discharge, ADLS patients benefited from their *pécule de sortie*, which the CMO confirmed as amounting to 30FF in 1933.²²³ This sum was the result of the accumulated daily payment, or *pécule*, for patient labour. Patients earned 0.20FF per day whatever the nature of their work; once they had earned their *pécule de sortie* they were permitted to use the money to buy chocolate, tobacco and other "luxuries". Patient workers at the Littlemore were not paid.

In Oxford, a social worker was attached to each of the outpatient clinics from 1936.²²⁴ A volunteer social worker assisted the Littlemore medical team for two months during 1937, obtaining full case histories from patients on admission and making arrangements for patients who were about to be discharged. Her services were much appreciated by staff, leading Dr Armstrong to observe that "a permanent psychiatric social worker will eventually be considered a necessity at this as well as many other mental hospitals".²²⁵ By 1938, in the absence of a permanent social worker, the Littlemore relied upon the City Mental Health Visitor and her assistants for help with obtaining information regarding new patients and for

²²¹ Rapport Médical, ADLS, 1931, [no page nos.].

²²² Rapport Médical, ADLS, 1933, [no page nos.].

²²³ Ibid.

²²⁴ BoC Report, LARs, 1936/7, 17.

²²⁵ MS Report, LARs, 1937/8, 8.

arranging after-care for discharged patients.²²⁶ A temporary part-time social worker, Miss Leslie, was appointed to the hospital staff on 1 January 1940.²²⁷ The after-care duties of the social worker are not discussed in any detail in the Littlemore reports, but it is plausible to assume, based on experience at the Maudsley, that they would include helping discharged patients with securing employment.

6.11 Conclusion

In the English provincial mental hospital in Oxford, although no specialist occupational therapist was employed, American-style occupational therapy (AOT) was delivered by the nurses to patients of various types. Patient work, that is, work that contributed to hospital maintenance (as opposed to OT), continued at the Littlemore, but did not appear to be essential to the hospital budget. At the ADLS in Le Mans, OT was not adopted, while work to support the institution was given to chronic and convalescent patients. The work carried out by patients made a significant contribution to the asylum budget. In other words, there was no change to the occupational regime that existed before World War I in the French institution. Acute patients were treated biologically at the ADLS, while at the Littlemore the MS preferred a blend of psychotherapy and OT.

The differences in the occupational regimes in French and English provincial institutions can be linked to several factors. The most important is that of the therapeutic preferences of the MS and CMO. As a result of his experiences during World War I, Dr Good of the Littlemore believed that psychotherapy and occupational therapy were the most effective treatments, although malaria therapy was used for patients suffering from GPI. After Good's retirement, Dr Armstrong continued to demonstrate a preference for psychotherapy and OT, although the new shock treatments were also deployed. The French CMOs, on the other hand, preferred biological treatments for the curable, acute patients. They did not consider OT or work as suitable therapy for acute patients; Dr Christy was emphatic in his distinction between the therapeutic approaches for curable and incurable patients; the first requiring the scientific skills of the neuro-psychiatrist and the second, the experience of the psychologist in re-educating patients.

²²⁶ MS Report, LARs, 1938/9, 8.

²²⁷ MS Report LARs, 1939/40, 8.

The differences in approach between the French CMOs and the English MSs are indicative of the different pathways to professionalisation taken by French and English psychiatry. In France, where psychiatry was slower to become established as an independent discipline, the profession was still closely aligned to neurology. Neurologists interpreted mental disorder from a physiological (or organicist) perspective and sought biological, rather than psychological, means to treat it. In Britain, on the other hand, where psychiatry was better established as an independent specialty and had fewer ties to neurology, psychiatrists were more inclined to view mental disorder from a holistic, or psychobiological perspective, and to consider psychological methods of treatment (as well as biological methods). This acceptance of the efficacy of psychological methods made English MSs more receptive to the use of OT as a means of active treatment, rather than simple distraction. The divergent pathways towards professionalisation can therefore be said to have had a significant influence on the take-up of OT and the use of occupation to treat acute patients.

Another significant factor in the different approaches to occupation in French and English institutions was finance. The difficulties experienced at the ADLS in providing basic facilities suggest that the contribution made by patient work to institutional finances was extremely important. The attention paid to recording and evaluating every aspect of patient work by the asylum administration emphasise this. In contrast, scant comments were made by the CMOs about the therapeutic importance of work. A debilitating lack of resources at the ADLS was the result of the severe damage to the French economy caused by World War I and the effects of the Depression, which began later in France than in England but whose effects were longer-lasting. La Sarthe was a poor department and Le Mans had yet to benefit from the financial boost to its local economy provided by Renault. Oxford, by contrast, was already experiencing the rewards of a rapidly developing automotive industry. The financial aspects of patient work were downplayed in English institutions, in line with the BoC's policy. Although the farm accounts show that a financial contribution was made by the patients who worked on the Littlemore farm, patient work in other parts of the hospital was not evaluated in the same way as at the ADLS. The emphasis at the Littlemore was on the therapeutic benefits of work and OT, rather than their financial contribution.

At the Littlemore, many patients were treated as outpatients, and did not require admission, thereby saving the local authority money and enabling more patients to remain

living and working in the community. The existence of a successful psychiatric outpatient department in Oxford (founded by Dr Good), which kept admissions to the hospital relatively low, meant that the Littlemore never suffered from overcrowding during the interwar period. The hospital enjoyed spare capacity and was able to take in “out-county” patients who paid a higher weekly maintenance charge than “in-county” patients. In contrast, the ADLS was overcrowded throughout the interwar period, particularly during the late 1930s. Le Mans did not have a psychiatric outpatient department, which were very rare outside Paris, despite a Ministry of Health notice encouraging their establishment in 1937. Overcrowding compromised all forms of treatment, including innovation in patient work and occupation. At the ADLS, nurses were overstretched, and space was limited. In contrast, nurses at the Littlemore had time to focus on patient occupation, which also gave them the opportunity to talk to patients and thereby glean valuable information for the medical team.

The two case studies of the ADLS and the Littlemore clearly illustrate that the introduction of OT was at once dependent on, and indicative of, a high level of professionalisation amongst the nursing staff. In Le Mans, the recruitment of experienced nurses was problematic and nurse training only began at the ADLS in 1937, when the introduction of the 40-hour week obliged the asylum to employ male nurses with no experience of, and little interest in nursing. Female nurses were provided by the religious order of La Charité d’Evron; while their nursing skills were good, continuity of care was lacking because of the nurses’ religious duties. In contrast, nursing at the Littlemore was more highly professionalised. Nurses were trained both in nursing and in OT provision and their experience was enhanced by a period spent at Oxford’s Radcliffe Infirmary. The ADLS CMOs also experienced difficulty in appointing interns and medical officers, which inhibited treatment provision. In the university town of Oxford such problems did not arise.

A focus on treatment was enhanced at the Littlemore following the Mental Treatment Act of 1930 that permitted voluntary admission of more acute, curable patients. Greater progress in this area was impeded by the presence of a substantial proportion of elderly, chronic and intellectually impaired patients, for whom care was not available in more appropriate specialist institutions. Larger numbers of acute patients gradually increased the requirement for OT delivered by the nurses on the wards, but incurable patients continued to outnumber the curable patients. It was the concentration of acute cases at the

metropolitan hospitals, and the effect that had on patient work, that set them apart from the provincial hospitals, particularly in France. The difference between the Maudsley and the Littlemore was one of degree, while that between the ADLS and the Asile Clinique and the HRH was more marked because there were fewer curable cases admitted to the ADLS (as indicated by the rate of cure).

Developments to improve the provision of care for patients after discharge were more advanced at the Littlemore. A psychiatric social service, deemed essential for the delivery of modern psychiatry by Edward Mapother of the Maudsley, and by the French Health Minister, Marc Rucart, was not something the ADLS could provide during the interwar period. The Littlemore, although unable to employ a PSW directly, was able to benefit from the services of a local authority PSW. After-care associations existed in both France and England, but provision was not universal in France. A Patronage Society was only established in La Sarthe in 1933. The existence of measures to support patients after leaving hospital represent another indicator of professionalisation. In England, provision of support in the provinces was more highly developed, which was in keeping with a higher discharge rate of patients from the Littlemore, compared with the ADLS.

Neither patient work nor OT at the provincial institutions, or at the metropolitan hospitals, prepared patients in a vocational sense for the labour market. On the one hand, attitudes towards ensuring that patients were self-sufficient on discharge had changed in the light of increased welfare measures and acceptance that joblessness was not a moral failing, but on the other hand, unemployment made recently recovered patients vulnerable to relapse and did not help to augment national productivity. In the provinces, however, fewer patients were likely to be discharged because of the high proportion of chronic and incurable cases in provincial institutions. From this perspective, rehabilitation for the labour market was less of a priority for provincial institutions than it was for metropolitan hospitals where a far greater proportion of patients were discharged each year.

Chapter 7:

Conclusion

This thesis has argued that developments in the way patient work and occupation were organised depended primarily on levels of professionalisation within French and English psychiatry and mental nursing. The divergent pathways to professionalisation taken by French and English psychiatry led to the uptake of new methods of occupational therapy in England during the 1920s and to their being overlooked in France until after World War II. In England, psychiatry developed as an independent discipline earlier than in France, allowing English psychiatry to break free of the rigidly organicist interpretation of mental disorder maintained by psychiatrists in France, where psychiatry was closely aligned with neurology. English psychiatrists developed a more holistic interpretation of mental disorder, and a “psychobiological” approach to treatment that incorporated occupational therapy. The adoption of occupational therapy as a medicalised form of active treatment for acute-stage patients also depended upon the specialist training of mental nurses, which was more advanced in England than in France. Whereas mental nurse training was available nationwide in England, in France its provision outside the capital was patchy. There, the calibre of individuals attracted to mental nursing, which was influenced by relatively poor pay and conditions, was low and this further compromised their ability to take advantage of whatever training was available.

The muted response by French psychiatrists to the new methods of occupational therapy emanating from Germany and the USA was also the result of the stringent budgetary constraints on French asylums that caused ADs to rely heavily on the financial contribution made by patient work. ADs, who shared responsibility for asylum management with CMOs, were reluctant to make any changes to the *status quo* that might jeopardise this contribution. CMOs, who had less autonomy than their English counterparts, lacked the authority to challenge the AD’s position. Furthermore, French CMOs preferred biological treatments, which in the French context did more to enhance the scientific credentials of psychiatry, leading to the persistence of traditional modes of patient work. In England, on the other hand, where American conceptions of OT had been in circulation since 1922, the

Macmillan Report of 1926 sought to downplay the economic contribution made by patient work and encouraged the prescription of occupation designed to benefit the patient rather than the institution. The adoption of occupational therapy became seen as the hallmark of a modern English mental hospital and an essential aspect of active treatment for all “grades” of patient, including acute and severely deteriorated patients.

This thesis has also argued that a rehabilitative rationale for work, so important during the nineteenth century in the absence of modern welfare measures, proved less significant during the interwar period. The evidence revealed an absence of attempts, in all the institutions studied, to prepare patients for the new working methods introduced by scientific management, or to provide them with experience of the type of work found in the growth areas of their local economy. In France, the priority for patient work was to fulfil institutional requirements, which had changed little since the nineteenth century. This resulted in the retention of outmoded working practices inside institutions that did not reflect the technological advances made in work environments outside. In England, a therapeutic rationale was prioritised over any economic or rehabilitative concerns. There, the main purpose of work and occupation was to return patients to health, rather than to prepare them for the labour market. This was best achieved through carefully supervised arts and crafts activities, of various levels of complexity, and work around the hospital, but not vocational training. Social services and other networks (such as convalescent homes) were developed during the interwar period to support patients in finding work or training schemes after discharge; the priority whilst in hospital was therapy.

7.1 How this study has contributed to contemporary scholarship

The comparison of patient work and occupation in French and English mental hospitals undertaken by this thesis has brought into sharp relief the different pathways to professionalisation taken by French and English psychiatry. Adopting a comparative methodology has not been without its difficulties but has paid rich dividends in its exposure of the divergent conceptions of mental disorder held by French and English psychiatrists. The French organicist approach that located mental disorder in the brain and central nervous system, compared and contrasted with the English holistic interpretation that took account of psychological and social as well as physiological factors, framed psychiatrists’ approaches to the prescription of work and occupation for patients.

French psychiatry's lack of independence from neurology, the dominant specialism in France during this period, ensured that French psychiatrists maintained an organicist interpretation of mental disorder, one that located the origin of mental disturbances in the brain and central nervous system rather than in the "psyche" or the mind. This organicism led to a rejection of psychological modes of treatment, including occupation, in favour of biological methods for acute cases. In England, psychiatry was better established as an independent discipline and, unlike French psychiatry, had not developed in tandem with neurology. This relative independence allowed English psychiatry to embrace a broader, more holistic view of mental disorder and to recognise the value of psychological methods of treatment, such as occupational therapy, which was considered an essential means of re-education and habit formation.

The comparative methodology also highlighted differences between approaches to occupation in the metropolitan and provincial mental hospitals studied. In France, the differences were far more marked than they were in England. In provincial France, psychiatrists tended to remain in "alienist" mould, providing custodial care for a predominantly incurable or chronic cohort of patients, rather than active treatment. Christy was an exception to this rule, indicated by his keenness to treat acute patients with "aggressive biological therapy", but he retained an organicist, neuropsychiatric approach and did not include OT within his therapeutic arsenal for acute patients. The new concepts of psychoanalysis circulating in Paris did not extend beyond the capital. The SLPM, based on the American model of care, was not recreated outside Paris before the outbreak of World War II, despite the intervention of the Health Minister in 1937. There was little enthusiasm for the proposed changes outside the capital, as von Bueltzingsloewen has highlighted.¹ In the case of the ADLS, as well as a lack of enthusiasm for OT, resources were non-existent. Not only did Christy experience difficulty in recruiting competent nursing staff, but he also found it impossible to appoint medical students as interns. There was no university in Le Mans at that time and medical students were not attracted to the town, or its overcrowded asylum.

¹ Von Bueltzingsloewen, *L'hécatombe Des Fous*, 282.

The situation was quite different in England. Both London and Oxford had medical faculties attached to their universities, so recruitment of junior medical staff was not a problem. The difference between the provision of occupation in metropolitan and provincial establishments was less obvious; it was more a matter of degree. Both institutions took a holistic view of mental disorder, providing psychotherapy as well as biological treatments. The Littlemore did not employ an occupational therapist but had trained nurses to fulfil the role. The Maudsley, on the other hand, had employed an occupational therapist since 1924 and began its own training school in 1932. At both institutions, however, OT was prescribed to acute patients. Although the Littlemore (until 1930) did not receive patients on a voluntary basis, its “open door” policy meant that most patients experienced a similar sense of freedom to Maudsley patients (although they were still subject to the law of 1890). Patients at the Maudsley, like those at the HRH, were free to come and go as they chose. The Littlemore’s “open door” policy was in marked contrast to the “closed” environment at the ADLS where patient work in the open air was compromised by fears that it would lead to escapes. Here, patient work was reserved for incurable, chronic and convalescent patients, organised along the same lines as it had been before World War I. Acute patients did not receive OT at the ADLS, where biological methods were preferred.

This study, through its analysis of the transfer of new ideas concerning OT developed in the USA and Germany, demonstrates the importance of international personal connections and the role played by political and scientific rivalries between nations, thereby adding to the genre of transnational history. The personal connections developed between the influential American psychiatrist and co-founder of the Mental Hygiene Movement, Adolf Meyer, and the young British doctors who worked with him in Baltimore during their training, both before and after World War I, were responsible for the transfer of American ideas to Britain. These young British doctors brought Meyer’s ideas back to Britain, introducing them into their hospital practice and promoting them in the professional journals. By the time British psychiatrists became aware of German methods of occupational therapy, through study visits to Gutersloh and Santpoort organised by the RMPA in the late 1920s and early 1930s, the American system was already well established. By contrast, the reception of German ideas in France was fraught with on-going feelings of *revanchisme* following defeat of France by Germany in the Franco-Prussian War of 1870-1 and by resentment of the German

usurpation of France's pole position in the ranks of continental psychiatry. The promotion of Hermann Simon's "More Active Therapy" by certain French psychiatrists, who either chose to overlook such concerns or to emulate the German model, fell on deaf ears, in part because of the on-going organicism of most French psychiatrists, but also because of the complicated relationship with German psychiatry.

This study highlights the role that professional reputation within medicine plays in the choice of therapeutic options. A need for respect and acceptance by the rest of the medical profession encouraged French psychiatrists to adhere to an organicist perspective that allowed them to retain a close association with the more prestigious discipline of neurology. Neurology was organicist; it specialised in diseases of the brain and the central nervous system, and as such was focused on physiology. The French, as Harry Paul observes, were especially proud of their scientific heritage, as the foundation of various scientific institutes (such as the Pasteur Institute, founded in 1888) during the nineteenth century, and state investment in scientific research during the early twentieth century attest.² This helps to explain the emphasis within French medicine on scientific method and the keenness of French psychiatrists to be regarded as scientific. Patient work and occupation were not sufficiently scientific to enhance psychiatry's reputation, as Dr Christy of the ADLS made plain. Malaria therapy for sufferers of general paralysis of the insane, or shock treatments for schizophrenia, were far more likely to augment its reputation than occupation, which was associated with the outmoded moral therapy.

Nevertheless, practices associated with moral therapy, which transformed the care of the insane in the late eighteenth and early nineteenth centuries, persisted well into the twentieth century. The asylum, with its extensive grounds and gardens, continued to be the main locus of care until at least the 1950s; a regular daily routine was maintained; staff were expected to treat patients with respect and kindness; restraint was only used as a last resort; and patients continued to be occupied with work and recreational activities. While the therapeutic efficacy of moral treatment alone began to be questioned after the 1840s, the practices associated with it were deemed humane and were carried on alongside the introduction of medicinal and biological treatments. Work and entertainment broke up the

² Harry W. Paul, *From Knowledge to Power: The Rise of the Science Empire in France 1860-1939* (Cambridge: Cambridge University Press, 1985), 2, 340.

monotony of the day and continued to provide a useful distraction for incurable, chronic and convalescent patients in both France and England. Although psychiatry turned away from the psychological interpretations of mental disorder espoused by its founding fathers Philippe Pinel and William Tuke, and towards the organicist explanation expounded by Bénédict-Augustin Morel, occupation continued to feature in French and English asylum regimes. This was in part pragmatic, since the work carried out by patients was extremely useful in offsetting institutional running costs and made patients more manageable. In the case of France, it was written into asylum law in 1838 and 1857 (and not amended subsequently) that patients should be provided with work and entertainment. Early twentieth-century occupational therapy built upon the teachings of the moral therapists, extending the therapeutic remit of occupation to include patients at the acute stage of their illness and those whose conditions were severe. Patient work in asylums continued, either relatively unchanged (as in France) or adapted as occupational therapy (as in England), for over 150 years after it was first introduced into asylums.

7.2 The Importance of Individuals

What became apparent whilst researching this thesis was the importance of individuals to the adoption or rejection of a therapeutic rationale for occupation. Édouard Toulouse, who denounced the rigid organicism of his French colleagues and favoured an American model of care, adopted a very different view of occupation to that of most French psychiatrists. His approach can be contrasted with that of Henry Christy in Le Mans, whose self-professed enthusiasm for neuropsychiatry and biological methods of treatment for acute patients meant that work remained confined to the chronic, incurable and convalescent patients. The enduring organicism of Porter-Philips delayed the opening of the occupational therapy unit at Bethlem until 1932, invoking the displeasure of the BoC, while Edward Mapother, whose foremost concern was that psychiatry should “do no harm”, responded cautiously to the emergence of the shock treatments. Mapother and his medical team, several of whom had worked with the influential Adolf Meyer in the USA, embraced the concept of the unity of mental disorder and recognised the benefits of occupational therapy as a means of re-education. Thomas Saxty Good became convinced of the efficacy of psychotherapy and occupation during World War I while treating shell-shocked soldiers. His preference for psychotherapy and his early adoption of OT set the tone for treatment at the Littlemore

during the interwar period. Good's innovative "open door" policy therefore marked him out as a pioneer among English interwar psychiatrists.

But none of these psychiatrists could have introduced properly supervised, graded, occupational therapy without well-trained staff. As Good remarked, "the greatest essential to any hospital's success is the human element, *i.e.* the staff and the way it fits in and pulls together".³ Skilled, dedicated nurses were essential to the provision of OT, as Paul Courbon observed in 1929.⁴ This was a problem in France, where mental nursing did not attract well-educated candidates and where training was not widely available. Christy found the standard of male nurses deplorable and felt compelled to begin a training course at the ADLS. In England, becoming qualified was not obligatory in most hospitals (although it was for senior staff at the Maudsley), but all hospitals provided training and encouraged nurses to sit the mental nursing examinations set by the MPA or the GNC. At the Littlemore, nurses spent three months training at the Radcliffe Infirmary, to gain experience of general nursing, as well as that of mental nursing. Good was clearly prepared to invest in his nursing staff, ensuring that they were relieved of their administrative duties so they could spend more time developing relationships with patients. Sufficient numbers of nurses were also crucial; Henri Claude was so short-staffed that he was unable to use the isolation rooms in the Faculty Clinic during the 1920s. Claude was hardly likely to be able to introduce OT in such conditions.

The emergence of a new band of paramedical professionals, the occupational therapists, during the interwar period in England contrasts with their absence from France until the 1950s. The new profession of OT, inspired by the American example, and encouraged by the BoC, led to the establishment of the first school of OT in England in 1930. No such school existed in France until 1954. As we have seen, a need for OT in England was created by the approach taken by English psychiatrists who regarded it as essential aspect of re-education. French psychiatrists during the interwar period took a very different approach and did not recognise the value of OT, preferring to focus on biological methods of treatment for acute patients. Interest in the therapeutic properties of occupation only came to the fore after World War II, when a major re-assessment of care for the mentally disordered took place,

³ Good, "History and Progress," 613.

⁴ Courbon, "Un voyage d'études," 399.

prompted by revelations of the neglect and ill-treatment of asylum patients between 1940 and 1945.⁵

7.3 Areas for future study

In future, attention might be turned towards how OT developed in France after World War II. As Nicolas Henckes has observed, interest in therapeutic work began to gather speed after Liberation in 1945 in the context of “institutional psychotherapy”.⁶ A group of young, militant psychiatrists, the so-called *L’Information psychiatrique*, was particularly influential in promoting “institutional psychotherapy” which they regarded as a return to the founding principles of modern psychiatry, as laid down by moral therapist Jean-Étienne Dominique Esquirol (1772-1840), pupil of the revered Philippe Pinel.⁷ Presumably, then, this change of heart regarding the value of therapeutic work was accompanied by an ideological shift away from the rigidly organicist stance of French psychiatry during the interwar years, and towards an approach that incorporated the psychological and social aspects of mental disorder. One member of the group *L’Information psychiatrique*, François Tosquelles, who allegedly escaped from Franco’s forces at the end of the Spanish Civil War, entered France as a refugee in 1939 with just two books, one of which was a copy of Hermann Simon’s *Aktivere Krankenbehandlung in der Irrenanstalt* (1929), outlining his theory of “more active therapy”. Tosquelles was inspired by Simon’s text (which had not been translated into French before World War II) to write his own guide to therapeutic patient work in 1967.⁸ It would be fascinating to discover whether “institutional psychotherapy” was introduced at the Asile Clinique and the ADLS and how it changed the nature of patient occupation in those institutions.

In England, an area that could be further explored is the anomaly between therapy and rehabilitation, between using occupation to restore mental health and to prepare people for the modern workplace. This was exposed after World War II and led to the introduction of Industrial Therapy (or IT). Despite the alleged potential of modern working practices to compromise mental health, factory-style workshops were recreated in many mental

⁵ Von Bueltzingsloewen, *L’hécatombe Des Fous*, 403.

⁶ Nicolas Henckes, “Réformer Et Soigner. L’émergence De La Psychothérapie Institutionnelle En France, 1944-1955,” in *Psychiatries Dans L’histoire*, ed. Jacques Arveiller (Caen: PUC, 2008), 278.

⁷ *Ibid.*, 281.

⁸ François Tosquelles, *Le Travail Thérapeutique En Psychiatrie* (Paris: Éditions du Scarabée, 1967).

hospitals during the 1950s, as Vicky Long has outlined, either in addition to, or in many cases, replacing OT workshops.⁹ The American style of OT that had been adopted during the interwar period, with its emphasis on hand-made arts and crafts, represented the antithesis of working practices in the modern factory. In the post-World War II context of de-institutionalisation, a renewed emphasis on vocational occupation led to criticisms of OT that failed to prepare patients for the workplace. As the locus of patient care began to shift from the hospital to the community, former in-patients were required to support themselves and needed the skills to do so. How the OT/IT debate panned out and how it affected occupation at the Maudsley, Bethlem and Littlemore hospitals would be an area for further study.

Whatever the rationale for patient work and occupation – therapeutic, economic or rehabilitative – it has consistently been part of the mental hospital regime since the late eighteenth century. The emphasis on each one of those rationales has changed over time in response to different prevailing social, economic and cultural circumstances and medical opinion. The use of occupation as an *active treatment*, as opposed to a means of offsetting costs or returning people to work, acts as a guide to the waxing and waning of psychiatrists' recognition and acceptance of the psychological and social causes of mental disorder. For new methods of occupational therapy to be adopted in the institutions studied, psychiatry had to be established as an independent discipline, without ties to a specialty that only conceived of mental disorder in physiological terms. Well-trained hospital staff working together towards the same goals, and adequate financial resources which allowed Chief Medical Officers and Medical Superintendents the freedom to use occupation therapeutically, rather than as a cost-saving device, were essential for the successful introduction of occupational therapy. Crucially, this study has shown how a comparative approach can add new insights to existing perspectives.

⁹ Long, "Work Is Therapy?," 342.

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APPENDICES

Institutional Tables

Appendix i: Metropolitan Institutions

- Asile Clinique
- Service Libre de Prophylaxie Mentale
- Maudsley
- Bethlem Royal

Appendix ii: Provincial Institutions

- Asile de la Sarthe
- Littlemore

Appendix iii: Timeline

i) Metropolitan Institutions:

The Asile Clinique, Ste Anne's, Paris

Table AC-1: to show male and female patient population of the Asile Clinique (comprising Male and Female Divisions and the Faculty Clinic) and the population of all the asylums in the Seine, 1919-1938, on 31 December.

	Males – Asile Clinique	Females – Asile Clinique	Total – Asile Clinique	Males – Seine	Females – Seine	Total – Seine
1919	568 – 51%	546	1,114	3,060	4,723	7,783
1921	600	509	1,109	3,752	5,584	9,338
1922	595	499	1,094	3,364	5,286	8,650
1923	522	533	1,055	3,414	5,411	8,825
1924	499	495	994	3,486	5,596	9,082
1925	506	512	1,018	3,478	5,754	9,232
1926	507	500	1,007	3,416	5,524	8,940
1927	466	457	923	3,564	5,617	9,181
1928	542	501	1,043	3,523	5,694	9,217
1929	571 = 53%	506	1,077	3,638	5,766	9,404
1930	581	502	1,083	3,835	5,847	9,682
1931	573	501	1,074	3,814	6,028	9,842
1932	915	716	1,631	4,531	6,575	11,106
1933	574	511	1,085	4,235	6,677	10,912
1934	582	510	1,092	4,519	6,647	11,166
1935	585	509	1,094	4,931	7,185	12,116
1936	577	513	1,090	5,351	7,550	12,901
1937	588 = 54%	496	1,084	5,653	6,900	12,553
1938						

ASILE CLINIQUE MEN'S DIVISION

Table AC-2: to show annual patient population of the Asile Clinique Men's Division (no details for 1920 or 1926):

	1919	1921	1922	1923	1924	1925
Present 1/1	266	380	405	394	401	404
Admitted during year	502	285	304	341	334	423
Total treated	768	665	709	735	735	827
Discharged	220	161	234	228	228	324
Deaths	175	99	81	106	103	101
Remaining	373	405	394	401	404	402

ASILE CLINIQUE MEN'S FIRST SECTION 1927-1938

Table AC-3: to show annual patient population of Asile Clinique Men's First Division from 1927 (following transformation of the service) to 1938:

	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938
Present 1/1	336	163	218	220	221	220	215	219	225	221	223	222
Admitted during year	148	190	275	257	189	190	217	259	248	221	203	386
Total treated	484*	353	493	477	410	410	432	478	473	442	426	608
Discharged	112	109	196	212	154	171	171	219	210	164	147	302
Deaths	21	26	77	44	36	23	42	34	42	55	57	60
Remaining	163	218	220	221	220	216	219	225	221	223	222	246

* Of whom 188 were passed to the 2nd Section following the separation of the service on 1 April.

ASILE CLINIQUE MEN'S SECOND SECTION 1927-1938

Table AC-4: to show annual patient population - Asile Clinique Men's Second Section (established 1927):

	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938
Present 1/1		180	217	243	244	245	252	262	245#	249		245
Admitted during year	225	276	316	298	320	242	284	236	225	192		469
Total treated	225	456	533	541	564	487	536	498	470	441		714
Discharged		183	226	239	270	200	230	203	186	150		404
Deaths	33	39	64	58	49	35	44	27	35	43		81
Remaining		234	243	244	245	252	262	268#	249	248		229

seem to have lost 23 patients overnight!

ASILE CLINIQUE WOMEN'S DIVISION 1919-1926

Table AC-5: to show annual patient population – Asile Clinique Women's Division:

	1919	1921	1922	1923	1924	1925	1926	1927
Present 1/1	361	382	413	343	372	365	362	318
Admitted during year	189	175	259	215	238	220	117	146
Total treated	550	557	672	558	610	585	479	464
Discharged	128	142	260	134	190	163	123	288
Deaths	40	42	69	52	55	60	38	24
Remaining	382	373	343	372	365	362	318	152

ASILE CLINIQUE WOMEN'S FIRST SECTION 1927-1938

Table AC-6: to show annual patient population – Asile Clinique Women's First Section:

	1927	1928	1929	1931	1932	1933	1934	1935	1936	1937	1938
Present 1/1	318	152	177	178	175	178	172	179	178	183	179
Admitted during year	146	96	107	166	138	172	221	213	243	260	253
Total treated	464	248	284	344	313	350	393	392	421	443	432
Discharged	288	60	95	149	114	124	188	170	197	211	197
Deaths	24	11	12	20	21	54	26	44	41	53	54
Remaining	152	177	177	175	178	172	179	178	183	179	181

ASILE CLINIQUE WOMEN'S SECOND SECTION 1927-1938

Table AC-7: to show annual patient population – Asile Clinique Women's Second Section:

	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938
Present 1/1	110	148 + 29*	177	178	169	178	175	187	182	181		179
Admitted during year	245	252	233	247	289	240	214	223	207	236		347
Total treated	405	400 + 29*	474	425	449	418	389	410	389	417		526
Discharged	224	190	177	111	194	192	179	202	181	192		266
Deaths	33	38	55	59	77	50	23	27	26	41		86
Remaining	148	177	178	169	178	176	187	181	182	184		174

* These patients were sent to the Pavilion for workers which opened on 24 Sept 1928.

Patient Work at the Asile Clinique

Table AC-8: Table to show numbers and percentages of patient workers at the Asile Clinique, and the percentage of workers.

Year	No. patients present on 31 Dec	Total No. Patient Workers	% Patient Workers
1921	1,109	315	28%
1922	1,094	302	28%
1923	1,055	279	26%
1924	994	210	21%
1925	1,018	297	29%
1926	1,007	205	20%
		Average pre-transformation	25%
1927	923*	306	33%
1928	1,043#	272	26%
1929	1,077	364	34%
1930	1,083	380	35%
1931	1,074	319	30%
1932	1,087	320	29%
1933	1,085	331	31%
1934	1,092	339	31%
1935	1,094	339	31%
1936	1,090	336	31%
1937	1,084	308	28%
1938#	1,110	311	28%
1939#	1,110	349	31%

* Numbers were lower in 1927 because the Pavilion Magnan had been made over to the Henri Rousselle Hospital and the new quarters for working patients, supposed to be completed in 1927, were not yet ready to receive patients (they were finally completed in November 1928).

@ From 1929, the full complement of 170 chronic patient workers (120 men and 50 women) were installed in their new workers' quarters.

Figures based on a daily average presence of 1,110 patients (592 men and 518 women), the numbers used for budgeting purposes, in absence of figures for the numbers of patients present on 31 December.

Table AC-9: Table to show the breakdown of male and female patient workers at the Asile Clinique, expressed as a percentage of the numbers of male and female patients present on 31 December:

Year	Total Population	Total Male population	Male workers	% Male workers	Total Female pop	Female workers	% Female workers
1921	1,109	600	?	?	509	?	?
1922	1,094	595	?	?	499	?	?
1923	1,055	522	151	29%	533	128	24%
1924	994	499	89	18%	495	121	24%
1925	1,018	506	187	37%	512	110	21%
1926	1,007	507	?	?	500	?	?
1927	923	466	?	?	457	?	?
1928	1,043	542	?	?	501	?	?
1929	1,077	571	206	36%	506	158	31%
1930	1,083	581	211	36%	502	169	34%
1931	1,074	573	192	34%	501	127	25%
1932	1,087	576	190	33%	511	130	25%
1933	1,085	574	192	33%	511	139	27%
1934	1,092	582	196	33%	510	143	28%
1935	1,094	585	194	33%	509	145	28%
1936	1,090	577	193	33%	513	143	28%
1937	1,084	588	167	28%	496	131	26%
1938	1,110	592	183	31%	518	128	25%
1939	1,110	592	212	36%	518	137	26%

Table AC-10: Table to show the numbers of patients from treatment divisions (presumed convalescent) who were working, after the chronic patients had moved into the quarters for working patients in Nov 1928. The numbers of chronic male (120) and chronic female (50) patients were deducted from the total number of working patients.

	Total no. male patients	Total no. male workers	Non-chronic male patient workers	% non-chronic male patient workers	Total no. female patients	Total no. female patient workers	Non-chronic female patient workers	% non-chronic female patient workers
1929	571	206	86	15%	506	158	108	21%
1930	581	211	91	16%	502	169	119	24%
1931	573	192	72	13%	501	127	77	15%
1932	576	190	70	12%	511	130	80	16%
1933	574	192	72	13%	511	139	89	17%
1934	582	196	76	13%	510	143	93	18%
1935	585	194	74	13%	509	145	95	19%
1936	577	193	73	13%	513	143	93	18%
1937	588	167	47	8%	496	131	81	16%
1938	592	183	63	11%	518	128	78	15%
1939	592	212	92	16%	518	137	87	17%

Tables AC-11: Summaries of Workshop Performance at the Asile Clinique, 1922 – 1934, showing the numbers of patients working in each workshop, the numbers of days worked by patients and the amount paid (the *pécule*):

Summary of Workshop Performance in 1922

Workshop	Staffing	No. Patient Workers	No. days worked by patients	Total Pécule paid	Average daily pécule
Market Gardening	Dir + 3	7	2,393	1,067F	0.44F
Fumisterie / smoke house	Dir + 1	1	118	47.20F	0.40F
Plumbing/Roofing/Stone-masonry	Dir + 2	5	1,572	956F	0.60F
Carpentry	Dir + 1	8	2,302		0.51F
Locksmiths	Dir	10	3,002	1,597F	0.53F
Painting	Dir + 4	2	656	231F	0.35F
Mechanics	Dir + 1	2	665	668F	1F
Laundry	Dir + 12	11	3,228	771F	0.23F
Ironing	Dir + 1	4	1,197	435F	0.35F
Shoe-making	Dir	4	1,355	525F	0.38F
Tailors	Dir + 1	11	3,373	1,412F	0.41F
Sewing Group A	Dir + 1	10	2,832	903F	0.31F
Sewing Group B	Dir + 2	17	5,268	1,569F	0.29F

Dir = workshop manager

Dir + 2 = workshop manager plus 2 other members of (paid) staff

Summary of Workshop Performance in 1923

Workshop	Staffing	No. Patient Workers	No. days worked by patients	Total Pécule paid	Average daily pécule
Market Gardening	Dir + 3	9	3,305	1,535F	0.46F
Fumisterie / smoke house	Dir + 1	1	16	6.40F	0.40F
Plumbing/Roofing/Stone-masonry	Dir + 2	3	1,258	782F	0.62F
Carpentry	Dir	8	2,857	1,146F	0.41F
Locksmiths	Dir	6	2,259	1,333F	0.59F
Painting	Dir + 4	3	1,079	377F	0.34F
Mechanics	Dir + 1	3	916	823F	0.89F
Laundry	Dir + 12	12	4,724	2,675F	0.56F
Ironing	Dir + 1	4	1,575	592F	0.37F
Shoe-making	Dir	3	1,175	518	0.44F
Tailors	Dir + 1	3	3,035	1,258F	0.41F
Sewing Group A	Dir + 1	10	3,166		0.33F
Sewing Group B	Dir + 1	17	6,178	1,848F	0.29F

Summary of Workshop Performance in 1924

Workshop	Staffing	No. Patient Workers	No. patient work days	Total Pécule paid	Average daily pécule
Market Gardening	Dir + 3	10	3,505	1,881F	0.53F
Fumisterie / smoke house	Dir + 1	1	57	23F	0.40F
Plumbing/Roofing/Stone-masonry	Dir + 4	3	1,168	722F	0.61F
Carpentry	Dir + 1	6	2,010	807F	0.40F
Locksmiths	Dir	7	2,119	1,407F	0.66F
Electricity	Dir	2	449	225F	0.50F
Painting	Dir + 2	3	724	255	0.35F
Mechanics	Dir + 1	2	816	774F	0.94F
Laundry	Dir + 12	13	3,755 3,579 – H 176 – F	2,295F 2,021 – H 274 – F	0.57F 0.57F
Ironing	Dir + 1	4	1,356	510F	0.37F
Shoe-making	Dir	5	1,420	586F	0.41F
Tailors	Dir + 1	7	2,235	945F	0.42F
Sewing Group A	Dir + 1	11	3,494	1,199F	0.34F
Sewing Group B	Dir + 1	20	6,116	1,841F	0.30F

Summary of Workshop Performance in 1925

Workshop	Staffing	No. Patient Workers	No. patient work days	Total Pécule paid	Average daily pécule
Market Gardening	Dir	12	3,687	1,663F	0.45F
Fumisterie / smoke house	Dir + 1	1	61	24.40F	0.40F
Plumbing/Roofing/Stone-masonry	Dir + 2	4	1,093	551F	0.50F
Carpentry	Dir + 1	6	1,834	879F	0.47F
Locksmiths	Dir	8	2,245	1,325F	0.59F
Electricity	Dir	3	805	248F	0.30F
Painting	Dir + 2	3	805	305F	0.37F
Mechanics	Dir + 3	1	365	548F	1.5F
Laundry	Dir + 12	12	4,122 3,688 - M 434 - W	2,322F 2,075 - M 246 - W	0.55 - H 0.56 - W
Ironing	Dir + 2	4	1,184	437F	0,37F
Shoe-making	Dir	5	1,493	597F	0.40F
Tailors	Dir + 1	8	2,264	904F	0.39F
Sewing Group A	Dir + 1.5	11	5,012	1,435F	0.28F
Sewing Group B	Dir + 1	20	5,657	1,728F	0.30F

Summary of Workshop Performance in 1926

Workshop	Staffing	No. Patient Workers	No. patient work days	Total Pécule paid	Average daily pécule
Market Gardening	Dir + 3	?	?	1,599F	?
Fumisterie / smoke house	Dir + 1.5	2	502	?	?
Plumbing/Roofing/Stone-masonry	Dir + 1	3	891	?	?
Carpentry	Dir + 1	5	1,695	?	?
Locksmiths	Dir	7	2,253	?	?
Electricity	Dir + 1	3	759	?	?
Painting	Dir + 2	3	747	?	?
Mechanics	Dir + 1	2	365	?	?
Laundry	Dir + 14	16	4,782 3,591 – M 1,191 – W	2,114F – M 621F – W	0.68F M 0.52 W
Ironing	Dir + 2	4	1,181	?	?
Shoe-making	Dir	6	1,576	?	?
Tailors	Dir + 1	7	2,200	?	?
Sewing Group A	Dir + 1.5	10	2,851	?	?
Sewing Group B	Dir + 1.5	18	?	?	?

Summary of Workshop Performance in 1927

Workshop	Staffing	No. Patient Workers	No. patient work days	Total Pécule paid
Market Gardening	Dir + ?	?	?	?
Fumisterie / smoke house	Dir + 2		458	?
Plumbing/Roofing/Stone-masonry	Dir + 1.5	?	1,039	?
Carpentry	Dir + 0.5		727	?
Locksmiths	Dir	"some"	?	?
Electricity	Dir + 1.5	3	749	?
Painting	Dir + 2	?	?	?
Mechanics	Dir + 1	1	365	907F 2.5F p/day
Laundry	Dir + 14	19	4,847 3,511 M 1,336 W	5,652F 4,316F/1.2F 1,336F/1F
Ironing	Dir + 1.5	5	1,482	1,116F 0.75F p/day
Shoe-making	Dir	6	1,739	1,391F 0.80F p/day
Tailors	Dir + 1	8	2,157	1,726F 0.80F p/day
Sewing Group A	Dir + 2	11	3,278	2,309F 0.70F p/day
Sewing Group B	Dir + 2.5	20	5,505	3,452F 0.63F p/day

Summary of Workshop Performance in 1928

Workshop	Staffing	No. Patient Workers	No. days' work	Total Pécule paid
Market Gardening	Dir + 3	?	2,171	?
Fumisterie / smoke house	Dir + 1	2	416	998F 0.80F p/day
Plumbing/Roofing/Stone-masonry	Dir + 1	?	?	?
Carpentry	Dir	3	1,035	3,061F 0.99F p/day
Locksmiths	Dir	?	?	?
Electricity	Dir + 0.5	?	?	?
Painting	Dir + 2	2	733	551F 0.75F p/day
Mechanics	Dir + 1	2	424	973F 0.30F p/day
Laundry	Dir + 13	17 (12 + 5)	5,777 4,225 - M 1,552 - W	169,123F
Ironing	Dir + 1.5	4	1,380	1,065F 0.77F p/day
Shoe-making	Dir	5	?	?
Tailors	Dir + 1	9 +1	2,701 2,543 M 158 W	M 2,069F – 0.81F p/day W 379F – 0.80F p/day
Sewing Group A	Dir + 1.5	13	3,574	2,591F 0.73F p/day
Sewing Group B	Dir + 1.5	20	5,314	3,407F

Summary of Workshop Performance in 1929

Workshop	Staffing	No. Patient Workers	No. days' Work	Total Pécule paid
Market Gardening	Dir + ?			
Fumisterie / smoke house	Dir + 1	2	469	375F 0.80F p/day
Plumbing/Roofing/Stone-masonry	Dir + 1	3	758	819F 1.08F p/day
Carpentry	Dir + 0.5			
Locksmiths	Dir			
Electricity	Dir + 1.5			
Painting	Dir + 2			
Mechanics	Dir + 1			
Laundry	Dir + 13	22 (16+6)	4,663 M 1,707 W	5,115F M 1.10F /day 1,707F W 1F /day
Ironing	Dir + 1	3		
Shoe-making	Dir	5	1,506	1,339F 0.89F /day
Tailors	Dir + 1	10 (8+2)	2,704 2,179 M 425 W	
Sewing Group A	Dir + 1	12	3,637	2,795F 0.80F /day
Sewing Group B	Dir + 3	18	5,408	3,326F 0.61F /day

Summary of Workshop Performance in 1930

Workshop	Staffing	No. Patient Workers	No. patient work days	Total Pécule paid
Market Gardening	Dir + ?			
<i>Fumisterie / smoke house</i>	Dir + 1			
<i>Plumbing/Roofing/Stone-masonry</i>	Dir + 1			
<i>Carpentry</i>	Dir + 0.5			
<i>Locksmiths</i>	Dir			
<i>Electricity</i>	Dir + 1.5			
<i>Painting</i>	Dir + 2			
<i>Mechanics</i>	Dir + 1			
Laundry	Dir + 13	17 (13+4)	4,808 M 1,404 W	5,272F / 1.09F 1,404F / 1F
Ironing	Dir + 1	4		
Shoe-making	Dir	3	1,271	1,213F 0.95 p/day
Tailors	Dir + 1	9 (6+3)	2,930 1,956 M 974 W	
Sewing Group A	Dir + 1.5	13	4,199	3,205F 0.79F p/day
Sewing Group B	Dir + 2	18	5,598	3,599F 0.64F p/day

Summary of Workshop Performance in 1932

Workshop	Staffing	No. Patient Workers	No. patient work days	Total Pécule paid	Average daily pécule
Market Gardening	2	8	2,499	2,025F	0.85F
Plumbing	2	2	816	1,004F	1.23F
Stone-masonry	3	3	984	849F	0.86F
Carpentry	2	4	1,418	2,081F	1.46F
Locksmiths	1	7	2,194	3,005F	1.56F
Electricity	2	2	753	1,278F	1.69F
Painting	5	3	?	?	?
Mechanics	2	1	365	913F	2.5F
Laundry	8 + 2 stokers	17 men 2 women	5,304 - M 870 - W	5,839F – M 870F - W	1.10F -M 1F – W
Ironing	1	5	1,857	1,574F	0.84F
Shoe-making	1	3	989	1,188F	1.20F
Tailors	2	4	1,863	2,348F	1,25F
Sewing Group A	1	14	4,294	3,230F	0.75F
Sewing Group B	1	24	7,315	4,969F	0.67F
No. patients employed in workshops Total patient workers 1932 % employed in workshops		99 320 31%			

Summary of Workshop Performance in 1934

Workshop	Staffing	No. Patient Workers	No. patient work days	Total Pécule paid	Average daily pécule
Market Gardening	3	11	3,550	2,897F	0.81F
Plumbing	2	2	?	985F	?
Stone-masonry	2	2	640	579F	0.89F
Carpentry	2	4	1,590	2,375F	1.49F
Locksmiths	1	5	1,792	2,748F	1.53F
Electricity	2	3	1,321	1,865F	1.41F
Painting	3	1	?	490F	?
Mechanics	2	1	'all year'	?	2.50F
Laundry	7 + 2	20 Men 3 Women	6,144 - M 934 - W	6,612F - M 934F - W	1.06F - M 1F - W
Ironing	1	6	1,758	1,552F	0.88D
Shoe-making	1	3	936	958F	1.02F
Tailors	2	5 Men 2 Women	1,630 - M 538 - W	? ?	? ?
Sewing Group A	1	19 - W	5,774	3,990F	0.69F
Sewing Group B	1	30 - W	9,316	6,708F	0.72F
No. patients employed in workshops		117			
Total patient workers 1932		339			
% employed in workshops		35%			

Table AC-12: Male nursing staff (of various grades): X 150.

Men's Service	Admissions Service	Faculty Clinic
1 Chief Supervisor	1 Chief Supervisor	1 Chief Supervisor
9 Senior nurses	1 Senior nurses	2 Senior nurses
10 Supplementary nurses	2 Supplementary nurses	1 Supplementary nurses
63 Nurses	25 Nurses	20 Nurses
7 Trainee nurses	2 Trainee nurses	3 Trainee nurses
2 Assistant trainee nurses		
92 – TOTAL	31 – TOTAL	27 – TOTAL

Table AC-13: Female nursing staff (of various grades): X 166.

Women's Service	Admissions Service	Faculty Clinic
1 Chief Supervisor	1 Chief Supervisor	1 Chief Supervisor
9 surveillantes	1 Senior nurse	1 Senior nurse
10 suppléantes	2 Supplementary nurses	3 Supplementary nurses
64 nurses	20 Nurses	15 Nurses
16 trainee nurses	7 Trainee nurses	6 Trainee nurses
2 assistant trainee nurses		7 Assistant trainee nurses
102 – TOTAL	31 – TOTAL	33 – TOTAL

Table AC-14: Total staff numbers for 1922: X 453.

Medical/Nursing Staff		Administrative /Technical /General	
CMOs	3	Asylum Director (AD)	1
Medical team	12	Bursar	1
Pharmacist	1	Administrative staff	23
Male Nurses	150	General Services staff	40
Female Nurses	166	Technical staff	56
TOTAL	332	TOTAL	121

ASILE CLINIQUE - FACULTY CLINIC (PROF HENRI CLAUDE)

Table AC-15: to show annual patient population – Faculty Clinic:

	1919	1920	1921	1922	1923	1924	1925	1926
Present 1/1 (M:F)	161 (80:81)		190 (117:73)	194 (118:76)	203 (127:76)	181 (72:109)	82 (37:45)	70 (38:32)
Admitted during year (M:F)	308 (191:117)		226 (114:112)	505 (244:261)	495 (193:302)	460 (183:277)	3,824 (1,885:1,939)	3,575 (1,690:1,885)
Total treated (M:F)	469 (271:198)		416 (231:185)	699 (362:337)	698 (320:378)	641 (255:386)	3,906 (1,922:1,984)	3,645 (1,728:1,917)
Discharged/Died (M:F)	272 (150:122)		222 (113:109)	495 (234:261)	517 (248:269)	466 (185:281)	3,836 (1,884:1,952)	3,567 (1,686:1,881)
Remaining (M:F)	197 (121:76)		194 (118:76)	204 (128:76)	181 (72:109)	175 (70:105)	70 (38:32)	78 (42:36)

	1927	1928	1929	1930	1931	1932	1933	1934
Present 1/1 (M:F)	177 (68:109)	180 (69:111)		181 (69:112)		185 (70:115)	183 (67:116)	182 (69:113)
Admitted during year (M:F)	447 (219:228)	410 (208:202)		413 (227:186)		313 (170:143)	354 (199:155)	367 (178:189)
Total treated (M:F)	624 (287:337)	590 (277:313)		594 (296:298)		498 (240:258)	537 (266:271)	549 (247:302)
Discharged/Died (M:F)	444 (218:226)	420 (209:211)		414 (227:187)		315 (173:142)	355 (197:158)	364 (175:189)
Remaining (M:F)	180 (69:111)	170 (68:102)		180 (69:111)		183 (67:116)	182 (69:113)	185 (72:113)

	1935	1936	1937	1938
Present 1/1 (M:F)	185 (72:113)	184 (70:114)	184 (67:117)	175 (67:108)
Admitted during year (M:F)	300 (132:168)	347 (172:175)	320 (182:138)	356 (125:231)
Total treated (M:F)	485 (204:281)	531 (242:289)	504 (249:255)	531 (192:339)
Discharged/Died (M:F)	301 (134:167)	347 (175:172)	329 (182:147)	351 (123:228)
Remaining (M:F)	184 (70:114)	184 (67:117)	175 (67:108)	180 (69:111)

SERVICE LIBRE DE PROPHYLAXIE MENTALE (AND THE HENRI ROUSSELLE HOSPITAL)

Table SLPM-1: To show patient movement at the Henri Rousselle Hospital and the Service Libre de la Prophylaxie Mentale (SLPM) Outpatients' Dept.

<i>Henri Rousselle Hospital</i>	1924	1925	1928	1929	1930	1931	1932
No. of days present – Men	1,501	1,582	1,665	1,580	1,455	1,558	1,598
No. of days present – Women	4,721	4,504	4,218	4,549	4,607	4,807	3,765
Total no. days – Men and Women	6,222	6,086	5,883	6,129	6,062	6,365	5,363
No. of Men admitted / discharged during year	62 /	54	69	70	84	72	47
No. of Women admitted during year	99	92	82	116	127	105	94
Total no. admissions – Men and Women	161	146	151	186	211	177	141
<i>Outpatients Dept.</i>							
No. of consultations during year – Men and Women	c.800	c.3,000	c.5,000	c.6,800	c.7,500	c.?	c.8,200

<i>Henri Rousselle Hospital</i>	1933	1934	1935	1936	1937	1938
No. of days present – Men	1,270	1,498	1,554	1,604	1,561	1,336
No. of days present – Women	2,716	1,815	3,142	2,879	3,160	3,115
Total no. days – Men and Women	3,986	3,313	4,696	4,483	4,721	4,451
Total no. existing on 1/1 (M:W)		8 (3:5)	9 (6:3)	16 (6:10)	12 (4:8)	14 (3:11)
No. of Men admitted / discharged during year	83 / 78	84 / 81	83 / 84	62 / 64	79 / 80	63 / 59
No. of Women admitted / discharged during year	81 / 83	55 / 56	98 / 85	73 / 75	78 / 75	73 / 78
Deaths (M:W)	2 (2:0)	1 (0:1)	0	0	0	1 (1:0)
Total no. remaining 31/12 (M:W)	8 (3:5)	9 (6:3)	18 (5:13)	12 (4:8)	14 (3:11)	12 (6:6)
<i>Outpatients Dept.</i>						
No. of consultations during year – Men and Women	c.7,800	c.8,200	c.8,700	c.7,500	c.8,200	c.7,800

Table SLPM-2: Table to show permanent members of staff for the SLPM centre and the Henri Rousselle Hospital.

Nos. of staff	SLPM – staff for the whole centre	Nos. of staff	Hospital staff
1	Medical Director	4	Medical Assistants
1	Bursar	4	Interns (medical students)
1	Administrator	21	Nurses
3	Clerks	6	Senior Nurses
1	Secretary	65	Cleaners/general staff
1	Publicity manager	4	Kitchen Personnel
1	Publicity clerk	1	Clerk
		2	Psychiatric Social Workers
		1	Pharmacy Assistant
	Laboratory Staff		
3	Laboratory directors		
4	Laboratory technicians		Outpatient Dept.
8	Laboratory assistants	3	Doctors
		1	Dentist
		1	Medical Assistant
		3	Nurses
		3	Psychiatric Social Workers
		3	Cleaners/general staff

Table SLMP-3: Staff Ratios at the Henri Rousselle Hospital (based on 182 beds):

Nos. Patients/beds	182
Nos. Nurses	27
Nurse: Patient ratio	1: 7
Nos. Doctors	9
Doctor: Patient ratio	1:20

METROPOLITAN INSTITUTIONS: The Maudsley Hospital

Table MH-1: Showing the numbers of patients resident at the Maudsley Hospital on 1 January (or 1 February); those admitted during the year and the total numbers treated during the year, indicating the gender of patients.

Year No.	Year	Resident at start of period – M	Resident at start of period – F	Admitted during year - M	Admitted during year – F	Total treated during year - M	Total treated during year - F	Total No. patients treated
1	To 31/1/1924					189	263	452
2	1/2/1924 - 31/1/25	65	77	190	258	233	335	590
3	1/2/25 – 31/1/26	58	78	197	355	255	433	688
4	1/2/26 – 31/12/26	52	96	189	360	241	456	697
5	1/1/1927 – 31/12/27	57	96	260	385	317	480	797
6	1/1/1928 – 31/12/28	52	91	310	343	362	434	796
7	1/1/1929 -12/31/29	64	105	269	309	333	414	747
8	1/1/1930 – 31/12/30	58	103	283	325	341	428	769
9	1/1/1931 – 31/12/31	75	109	264	348	339	457	796
10	1/1/1932 – 31/12/32	77	111	299	403	376	514	890
11	1/1/1933 – 31/12/33	93	133	271	423	364	556	920
12	1/1/1934 – 31/12/34	94	136	300	413	394	549	943
13	1/1/1935 – 31/12/35	85	131	322	422	407	553	960

Table MH-2: Table to Show Staffing Levels at the Maudsley Hospital:¹

Staff	1923	1931	1935
<i>Medical team (mental illness):</i>	<i>4</i>	<i>12</i>	<i>15</i>
Medical Superintendent (MS)	1	1	1
Deputy MS#	1	1	1
First Assistant Medical Officer (MO)#	-	1	-
Clinical Director	-	-	1
Second Assistant MO	-	1	3
Assistant MOs	2	5	4
Assistant MOs (part-time)	-	2	4
Assistant MOs (temporary)	-	1	1
Consultants (physical conditions)	5	5	6
Chaplain	1	1	1
<i>Nursing staff:</i>	<i>62</i>	<i>78</i>	<i>94</i>
Matron	1	1	1
Assistant Matron	1	1	1
Home sister	-	-	1
Sisters	7	7	8
Nursing sisters	18	20	24
Female staff nurses or probationers	23	34	42
Male or female probationer nurses	12	15	17

¹ Maudsley Annual Report 1936, 3.

<i>Miscellaneous:</i>			
Pharmacist	1	1	1
Pharmacist (part-time)	-	-	1
Almoner	1	2	-
Social workers	-	1	4
Psychologists	-	1	2
Occupations Officer (employed 1924)	-	1	1
Masseuse	-	2	2
Student supervisor (of LSE student social workers)	-	2	2
<i>Clerical Staff:</i>			
Clerk and storekeeper	1	-	-
Clerk and steward	-	1	1
First assistant clerk	-	1	1
Second assistant clerk	-	-	1
Assistant clerks	1	3	3
MS's clerk	1	1	1
Records clerk	-	1	1
Women clerks	-	1	2
<i>Domestic Staff:</i>			
Cook housekeeper	1	-	-
Cook	1	1	-
Kitchen superintendent	-	-	1
Assistant cook	1	1	2
Hospital maids	15	24	28
Seamstress	-	1	1
Hall porter	1	1	1
Telephone operator	-	-	1
Storeman	2	2	2
Gardener	1	1	1

Garden labourer	-	1	1
Garden labourer (part-time)	-	-	1
Dispensary boy	-	1	-
<i>Maintenance Staff:</i>			
Foreman-in-charge	-	1	1
Carpenter	1	1	1
Upholsterer	-	1	1
General tradesman	1	1	1
Labourer	1	1	1
TOTALS	102	152	183

Table MH-3: Table to show staff to patient ratios:

	1923	1931	1935
Patient Numbers (on 1 Jan)	157	184	216
Number of Nurses*	62	78	94
Ratio of Nurses to Patients	1:2.5	1:2.4	1:2.3
Number of Doctors*	4	12	15
Ratio of Doctors to Patients	1:39	1:15	1:14

* Not all of these nurses/doctors were on duty at any one time; the ratio of day and night staff is not known, nor can the effect of staff holidays/days off/sick leave be accurately assessed.

These doctors also worked in the outpatients department.

METROPOLITAN INSTITUTION: Bethlem Royal Hospital

Table BR-1: Table to show the total patient population 1919-1930:

	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929
Present on 1 Jan (M:F)	210* (75:135)	226 (85:141)	213 (87:126)	243 (105:138)	234 (103:131)	224 (103:121)	223 (103:120)	218 (97:121)	208 (20:118)	202 (89:113)	196 (83:113)
Admissions during year	240 (89:151)	261 (110:151)	298 (125:178)	187 (84:103)	174 (73:101)	228 (87:141)	272 (106:166)	298 (124:174)	248 (104:144)	235 (103:132)	220 (91:129)
Total treated during year	450 (164:286)	487 (195:232)	511 (212:299)	430 (189:241)	408 (176:232)	452 (190:262)	495 (209:286)	516 (221:295)	456 (194:262)	437 (192:245)	416 (174:242)
Recoveries (M:F)	97 (32:65)	124 (46:78)	132 (50:82)	83 (39:44)	74 (26:48)	107 (43:64)	106 (49:57)	124 (51:73)	82 (28:54)	82 (43:39)	84 (35:49)
Relieved (M:F)	31 (12:19)	49 (19:30)	25 (11:14)	24 (9:15)	22 (11:11)	17 (4:13)	29 (11:18)	20 (9:11)	19 (10:9)	30 (12:18)	24 (8:16)
Not improved (M:F)	76 (21:55)	77 (29:48)	91 (34:57)	64 (19:45)	66 (25:41)	79 (32:47)	121 (41:80)	137 (61:76)	125 (53:72)	93 (30:63)	73 (31:42)
Deaths (M:F)	20 (14:6)	26 (14:12)	20 (12:8)	25 (19:6)	22 (11:11)	26 (8:18)	21 (11:10)	27 (10:17)	28 (14:14)	32 (19:13)	29 (16:13)
Remaining 31 Dec (M:F)	226 (85:141)	211 (87:124)	243 (105:138)	234 (103:131)	224 (103:121)	223 (103:120)	218 (97:121)	208 (90:118)	202 (89:113)	196 (83:113)	178 (76:102)
Average daily no. resident	262# (94:168)	210 (85:125)	219 (89:130)	213 (91:122)	209 (97:112)	205 (91:114)	206 (93:113)	214 (95:119)	209 (92:117)	198 (90:108)	196 (83:113)
% recoveries on admissions (M:F)	47.7% (43.75%: 48.9%)	47.85% (30.5%: 60.49%)	48.4% (47%: 49.4%)	54.76% (58.54%: 51.16%)	55.55% (39.39%: 66.66%)	55.78% (45%: 63.63%)	46.73% (56.41%: 41.18%)	56.38% (41.18%: 65%)	41.84% (32.56%: 49%)	37.7% (43.87%: 31.96%)	27.27% (24.13%: 29.72%)

* Included in these figures were the paying patients (see separate table, below) and both certified and voluntary patients (see separate table, below)

of whom were 211 certified (77 men/134 women) and 51 voluntary (17 men/34 women) patients

	1930	1931	1932	1933	1934	1935	1936	1937	1938	1939
Present on 1 Jan (M:F)	177 (76:84)	77 (33:44)	174 (65:109)	207 (88:119)	206 (82:124)	224 (99:125)	228 (103:125)	218 (97:121)	224 (96:128)	215 (90:125)
Admissions during year	122 (52:70)	241 (100:141)	259 (122:137)	211 (96:115)	235 (103:132)	234 (76:158)	229 (81:148)	233 (76:157)	229 (82:147)	262 (98:164)
Total treated during year	299 (128:171)	318 (133:185)	433 (187:256)	418 (184:234)	441 (185:256)	458 (175:283)	457 (184:273)	451 (173:278)	453 (178:275)	477 (188:289)
Recoveries (M:F)	34 (19:15)	20 (11:9)	94 (40:54)	82 (43:39)	92 (38:54)	92 (31:61)	104 (33:71)	104 (32:72)	117 (40:77)	124 (50:74)
Relieved (M:F)	40 (11:29)	21 (10:11)	25 (18:7)	29 (13:16)	26 (11:15)	29 (8:21)	26 (14:12)	23 (9:14)	38 (12:26)	40 (12:27)
Not improved (M:F)	142 (63:79)	35 (13:22)	83 (30:53)	75 (27:48)	85 (31:54)	90 (27:63)	87 (33:54)	76 (51:25)	70 (31:39)	82 (28:54)
Deaths (M:F)	6 (2:4)	26 (13:13)	24 (11:13)	26 (19:7)	14 (6:8)	19 (6:13)	22 (7:15)	24 (11:13)	13 (5:8)	8 (2:6)
Remaining 31/12 (M:F)	77 (33:44)	174 (65:109)	207 (88:119)	206 (82:124)	224 (99:125)	228 (103:125)	218 (97:121)	227 (77:150)	215 (90:125)	223 (95:128)
Average daily no. resident	97 (42:55)	137 (54:83)	194 (77:117)	208 (88:120)	211 (89:122)	225 (100:125)	215 (93:122)	224 (96:128)	220 (99:121)	207 (87:120)
% Recoveries on Admissions	27.86% (36.5%: 21.4%)	8.3% (11%: 6.4%)	36.29% (32.78%: 39.42%)	38.86% (44.79%: 33.91%)	39.15% (36.89%: 40.91%)	39.31% (40.79%: 38.61%)	45.41% (40.74%: 47.97%)	44.63% (42.1%: 45.86%)	51.09% (48.79%: 52.38%)	47.32% (51.02%: 45.12%)

Table BR-2: Table to indicate the numbers of patients who attended Bethlem's entertainments' programme and divine service; who were "usefully employed"; and who were granted parole or went out for trips in the car (as reported by the Board of Control inspectors).

Year	Usefully employed	Entertainments	Divine Service	Parole	Trips out in the car	Walking out under care	Patients attending arts and crafts dept
1919	NM	"fairly well attended"	"fairly well attended"	9	NM	48	
1920	65 (45:20)	80	38	10 (6:4)	20 (10:10)	42 (26:16)	
1921	NM	NM	30+ (12:18)	15 (11:4)	90 (42:48)	52(32:20)	
1922	62	84	33	6	60	51	
1923	NM	NM	NM	NM	NM	NM	
1924	"very satisfactory"	"very satisfactory"	"very satisfactory"	11	NM	"very satisfactory"	
1925 – June / Nov	75 – June 58 – Nov	85 – June 79 – Nov	18 – June 36 – Nov	9 (2:7)-Jun 6 (4:2)-Nov	22 - June 80 - Nov	NM / 16	
1926 – Nov	NM	75 (35:40)	45 (25:20)	4 (1:3)	NM	NM	
1927	NM	70 (35:35)	30 (10:20)	8(3:5)	NM	14 (6:8)	
1928	62	80	30-40	5	30	20	
1929	NM	75 (35:40)	31 (12:19)	6 (4:2)	NM	NM	
1930#	NM	NM	NM	NM	NM	NM	
1932	NM	NM	NM	NM	NM	NM	36 (14:22)
1933	NM	NM	NM	NM	NM	NM	179 (106:73)
1934	NM	86 (40:46)	64 (26:38)	NM	NM	NM	203 (121:82)
1935	NM	110	100	NM	NM	NM	306
1936	NM	NM	NM	31	NM	48	325
1937	NM	NM	NM	NM	NM	NM	335 (238:97)
1938	NM	NM	NM	NM	NM	NM	355 (265:90)
1939	NM	NM	NM	NM	NM	NM	317 (234:83)

NM = not mentioned

Table BR-3: Table to show Staffing levels at Bethlem in 1921; 1929; 1933 and 1938:

	1921	1929	1933	1938
<i>Medical Staff:</i>	5	5	5	5
Physician Superintendent	1	1	1	1
House Physicians	2	2	2	2
Senior House Physician	1	1	1	1
Junior House Physician	1	1	1	1
Pathologist	1	1	1	1
Dental Surgeon	1	1	1	1
Pharmacist	1	1	1	1
Radiologist	1	1	1	1
Chaplain	1	1	1	1
<i>Nursing Staff:</i>	84	79	95	95
Matron	1	1	1	1
Head Male Nurse	1	1	1	1
Female nurses (day + night)	38 + 7	38 + 5	43 + 9	43 + 9
Males nurses (day + night)	30 + 7	27 + 7	34 + 7	34 + 7
<i>Other:</i>				
Physiotherapist	1	1	1	1
Psychologist	1	1	1	1
Occupational therapist	-	-	1	1

Other Staff mentioned in the accounts: Organist; Steward's department; Kitchen staff; Housemaids and Ward Cleaners; Linen Room Maids; Engineer and Stokers; Clerk of Works; Carpenters; Porters; Gardeners and Labourers; Cleaners; Mattress-maker.

Table BR-4: Table to show staff to patient ratios:

	1921	1929	1933	1938
Patient Numbers (1 st January)	213	196	207	224
Number of Nurses*	84	79	95	95
Ratio of Nurses to Patients	1 : 2.5	1 : 2.5	1 : 2.2	1 : 2.4
Number of Doctors*	5	5	5	5
Ratio of Doctors to Patients	1 : 43	1 : 39	1 : 41	1 : 45

* Not all of these nurses/doctors were on duty at any one time; the ratio of day and night staff is not known, nor can the effect of staff holidays/days off/sick leave be accurately assessed.

ii) **PROVINCIAL INSTITUTIONS: Asile de la Sarthe, 1919-1939**

Table AS-1 to show population movement 1919-1939:

	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929
Present on 31 Dec (male:female)	721	588#	604 195:409	614 198:416	621 205:416	648 216:432	683 235:448	707 266:441	757 290:467	742 289:453	777 297:480
Admissions during year (male:female)	189 75:114	177 71:106	134	123	138 57:81	154 64:90	146 81:65	153 67:86	106 41:65	139 49:90	108 39:69
Total treated during year	910	565	738	737	759	802	829	860	863	881	885
Leaving the asylum:	121	112	74	60	58	68	72	58	63	53	45
Cured			17	19	24	22	23	20	15	11	5
Improved			34	26	16	30	33	21	34	28	24
Other			23	15	18	16	16	17	14	14	16
Deaths	201#	49	50	56	53	51	50	45	58	51	58
Average no. residents	609	594	615	618	642	658	692	745	746	761	777

high death rate in 1919/fall in patient nos.1920 due to influenza epidemic

	1930	1931	1932	1933	1934	1935	1936	1937	1938	1939
Present on 31 Dec (male:female)	782 297:485	792 298:494	799 305:494	812 312:500	831 335:496	837 347:490	845 331:514	869 343:526	879 362:517	899 373:526
Admissions during year	122 46:76	118 42:76	142 49:93	142 68:74	162 76:86	171 71:100	157 67:90	172 82:90	165 71:94	231 127:104
Total treated during year	904	910	941	954	993	1008	1002	1041	1044	1130
Leaving the asylum	60	47	54	60	91	89	81	94	72	117
Cured	16	15	5	1	-	-	8	10	6	29
Improved	26	14	28	29	36	46	47	55	38	54
Other	18	18	21	30	59	43	26	29	28	34
Deaths	52	64	75	63	65	74	52	68	73	65
Average no. residents	791	796	812	822	843	857	854	863	883	918

Asile de la Sarthe: Patient Work

Table AS-2: to show the number of days worked by male paying and pauper patients in each employment category:

MALES	1923	1923	1923	1925	1925	1925	1927	1927	1927	1929	1929	1929
Type of work	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total
Farmyard	1,482	-	1,482	1,457	-	1,457	1,680	-	1,680	2,026	77	2,103
Bakery	110	172	282	317	-	317	488	-	488	299	-	299
Laundry	2,579	220	2,799	2,398	710	3,108	2,528	612	3,140	3,208	668	3,876
Wood yard	2,207	-	2,207	2,282	584	2,866	2,572	384	2,956	1,972	450	2,422
Shoe Making	532	-	532	540	-	540	460	-	460	308	-	308
Kitchen	1,606	566	1,606	1,551	-	1,551	1,682	-	1,682	1,540	205	1,745
Farming	4,539	-	4,539	4,161	1,226	5,387	3,975	951	4,926	4,278	489	4,767
Clerical Work	590	-	590	1,076	-	1,076	918	-	918	1,175	-	1,175
Tin-plate Making	314	-	314	459	-	459	298	-	298	500	-	500
Stone Masonry	292	-	292	425	-	425	306	-	306	308	-	308
Housework	5,377	414	5,786	7,035	1,131	8,166	7,284	1,634	8,918	6,943	1,245	3,188
Carpentry	572	-	572	521	-	521	220	78	298	206	46	252
Painting	228	-	228	352	-	352	132	-	132	-	-	-
Locksmiths	-	-	-	327	-	327	383	-	383	308	-	308
Exterior maintenance	1,817	-	1,817	1,202	152	1,354	1,351	229	1,580	1,217	415	1,632
TOTALS	22,240	1,372	23,612	24,103	3,803	27,906	24,277	3,888	28,165	24,288	3,595	27,883

MALES	1930	1930	1930	1932	1932	1932	1934	1934	1934	1936	1936	1936
Type of work	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total
Farmyard	1,408	50	1,458	1,467	-	1,467	1,832	102	1,934	1,720	204	1,924
Bakery	334	-	334	618	83	701	614	-	614	640	-	640
Laundry	3,387	540	3,927	3,117	591	3,708	3,284	614	3,898	4,235	308	4,543
Wood yard	2,846	589	3,435	2,857	513	3,370	3,519	-	3,519	3,157	-	3,157
Shoe Making	308	-	308	284	66	350	409	278	687	-	308	308
Kitchen	1,438	308	1,746	1,676	309	1,985	1,535	307	1,842	1,950	133	2,083
Housework	6,457	842	7,299	8,016	875	8,891	10,485	1,045	11,530	10,656	928	11,584
Clerical Work	1,176	-	1,176	1,193	51	1,244	1,186	230	1,416	924	308	1,232
Tin-plate Making	492	-	492	564	-	564	614	-	614	359	-	359
Stone Masonry	232	-	232	258	-	258	307	-	307	924	-	924
Carpentry	462	-	462	387	-	387	307	-	307	539	77	616
Painting	-	-	-	619	-	619	564	178	742	488	385	873
Locksmiths	284	130	414	309	206	515	331	-	331	308	-	308
Exterior maintenance	1,365	290	1,655	1,567	249	1,816	793	257	1,050	443	127	570
TOTALS	24,485	3,368	27,853	26,852	3,434	30,286	30,896	3,510	34,406	32,360	3,163	35,523

MALES	1937	1937	1937
Type of work	Pauper	Paying	Total
Farmyard	1,629	-	1,629
Bakery	612	-	612
Laundry	4,285	152	4,437
Woodyard	2,271	-	2,271
Shoe Making	-	306	306
Kitchen	2,090	-	2,090
Farming	5,139	410	5,549
Clerical Work	868	567	1,455
Tin-plate Making	306	-	306
Stone Masonry	767	301	1,068
Housework	10,733	684	11,417
Carpentry	437	229	666
Painting	561	-	561
Locksmiths	343	-	343
Exterior maintenance	612	-	612
TOTALS	30,653	2,669	33,322

Table AS-3: to show the number of days worked by female paying and pauper patients in each employment category:

FEMALES	1923	1923	1923	1925	1925	1925	1927	1927	1927	1929	1929	1929
Type of work	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total
Farmyard	1,452	-	1,452	1,220	-	1,220	800	-	800	918	183	1,101
Laundry	3,822	-	3,822	4,252	26	4,278	4,542	-	4,542	4,220	-	4,220
Lingerie	1,595	752	2,347	989	1,037	2,026	1,518	608	2,126	1,562	610	2,172
Sewing	13,334	1,156	14,490	12,877	1,831	14,708	13,457	1,090	14,547	12,974	756	13,730
Kitchen	7,296	306	7,602	7,707	305	8,012	6,517	304	6,821	6,499	305	6,804
Housework	8,341	1,244	9,585	9,025	1,188	10,213	8,094	966	9,060	11,554	610	12,671
Pharmacy	612	-	612	610	-	610	608	-	608	610	-	610
Mending	5,096	178	5,274	4,225	301	4,526	3,440	141	3,581	2,907	123	3,030
Ironing	2,104	-	2,104	1,907	305	2,212	1,824	304	2,128	1,880	305	2,185
Knitting	2,119	497	2,616	1,331	632	1,963	865	687	4,100	301	647	4,046
TOTALS	45,771	4,133	49,904	44,143	5,625	49,768	41,665	4,100	45,765	43,925	4,046	47,971

FEMALES	1930	1930	1930	1932	1932	1932	1934	1934	1934	1936	1936	1936
Type of work	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total	Pauper	Paying	Total
Farmyard	912	228	1,140	463	309	772	307	236	543	309	-	309
Laundry	3,838	-	3,838	3,448	-	3,448	3,129	-	3,129	3,988	155	4,143
Lingerie	1,677	608	2,285	966	618	1,584	461	833	1,294	1,389	454	1,843
Sewing	12,228	866	13,094	13,920	837	14,757	14,786	1,166	15,952	14,801	1,993	16,794
Kitchen	6,591	472	7,063	5,998	386	6,384	6,202	410	6,612	6,265	300	6,565
Housework	9,162	779	9,941	9,576	218	9,794	10,249	1,354	11,603	16,094	1,477	17,571
Pharmacy	760	-	760	618	-	618	614	-	614	309	309	618
Mending	6,313	289	6,602	9,146	508	9,654	9,122	780	9,902	3,951	490	4,441
Ironing	1,873	304	2,177	2,488	309	2,797	1,838	334	2,172	2,907	-	2,907
Knitting	532	678	1,210	463	655	1,118	307	675	982	1,188	-	1,188
TOTALS	43,886	4,224	48,110	47,086	3,840	50,926	47,015	5,788	52,803	51,201	5,178	56,379

FEMALES	1937	1937	1937
Type of work	Pauper	Paying	Total
Farmyard	308	-	308
Laundry	4,443	153	4,596
Sewing	16,836	2,039	18,875
Kitchen	6,209	56	6,265
Lingerie	1,232	616	1,848
Housework	11,735	614	12,349
Pharmacy	308	-	308
Mending	3,571	580	4,151
Ironing	2,947	-	2,947
Knitting	6,279	837	7,116
TOTALS	55,334	5,208	60,537

Table AS-4: To show the breakdown of staff at the Asile de la Sarthe.

Staff	1919	1933	1939
<i>Medical team:</i>			
Chief Medical Officer (CMO)	1	1	1
Assistant Medical Officer (AMO)	-	-	1
Intern(s)	-	-	1
<i>Nursing staff – Male Side</i>	<i>34 gardiens</i>	<i>42 gardiens#</i>	
Chief Warden	1	1	
Under-Warden	1	1	
Wardens (“surveillants”)	26	35	
Servants for the paying patients	2		
Wardens overseeing patient workers	2	5	
Cleaners	2	2	
<i>Nursing staff – Female Side:</i>	<i>74 sisters*</i>	<i>43 sisters</i>	
Superior/chief warden	1	1	
Wardens (“surveillantes”) based in the quarters	46 + 2		
Wardens in general services	16		
Cleaners for the paying patients’ division	9		

* There were many more female nurses (les religieuses) because they worked part-time in order to fulfil their religious observances.

Of whom, two were night staff and 26 were on duty at any one time after deductions were made for days off, etc, looking after 335 patients

Table AS-5: Table to show staff to patient ratios at the ADLS.

	Nos. Patients	Nos. Nurses – day	Ratio Nurses: Patients
1933	812	66	1 : 12

PROVINCIAL INSTITUTIONS: The Littlemore Hospital, 1923-1939

LM-1: Table to show the patient population of the Littlemore Hospital 1923-1939

	1923	1924	1925	1926	1927	1928	1929	1930	1931
Present on 1 Jan (M:F)	552 (223:329)	602 (276:326)	606 (266:340)	667 (222:445)	707 (254:453)	729 (268:461)	743 (273:470)	735 (282:453)	787 (295:492)
Admissions during year	182 (104:78)	156 (52:104)	245 (62:183)	182 (77:105)	146 (57:89)	142 (54:88)	148 (70:78)	194 (66:128)	130 (55:75)
Total treated during year	734 (327:407)	758 (328:430)	851 (328:523)	849 (299:550)	853 (311:542)	871 (322:549)	891 (343:548)	929 (348:581)	917 (350:567)
Recoveries (M:F)	73 = 40% (29:44)	70 (25:45)	44 (23:21)	26 = 14% (8:18)	14 (7:7)	37 = 26% (15:22)	32 = 22% (17:15)	20 (12:8)	17 (10:7)
Relieved (M:F)	5 (2:3)	24 (11:13)	46 (14:32)	43 (11:31)	48 (14:34)	27 (10:17)	52 (12:40)	47 (11:36)	36 (8:28)
Not improved	1 (1:0)	14 (9:5)	46 (45:1)	15 (4:11)	5 (2:3)	12 (5:7)	13 (11:2)	12 (7:5)	11 (8:3)
Deaths	42	44 (17:27)	48 (24:24)	59 (22:37)	57 (20:37)	52 (19:33)	59 (21:38)	63 (23:40)	67 (39:28)
Total no. leaving (M:F)	132 (51:81)	152 (62:90)	184 (106:78)	142 (45:97)	124 (43:81)	128 (49:79)	156 (61:95)	142 (53:89)	131 (65:66)
Average daily no. resident	556 (239:317)		598 (229:369)	704 (250:454)	711 (256:455)	721 (266:455)	731 (275:456)	759 (292:467)	782 (290:492)
No. days resident	207,836	215,597	229,306	258,772	261,965	265,228	267,344	281,244	286,240

	1932	1933	1934	1935	1936	1937	1938	1939
Present on 1 Jan (M:F)	786 (285:501)	805 (299:506)	798 (296:502)	809 (299:510)	828 (301:527)	865 (321:544)	878 (329:549)	891 (333:558)
Admissions during year (M:F)	176 (78:98)	217 (88:129)	200 (79:121)	203 (82:121)	232 (110:122)	225 (88:137)	213 (83:130)	230 (89:141)
Total cases treated (M:F)	962 (363:599)	1,022 (387:635)	998 (375:623)	1,012 (381:631)	1,060 (411:649)	1,090 (409:681)	1,091 (412:679)	1,121 (422:699)
Recoveries (M:F)	22 = 13% (14:8)	30 = 14% (13:17)	30 = 15% (15:15)	29 = 14% (13:16)	33 = 14% (21:12)	63 = 28% (21:42)	61 = 29% (22:39)	63 = 27% (32:31)
Relieved (M:F)	59 (22:37)	68 (26:42)	66 (21:45)	60 (30:30)	69 (25:44)	46 (23:23)	43 (15:28)	51 (13:38)
Not improved (M:F)	7 (3:4)	43 (19:24)	36 (15:21)	23 (7:16)	17 (10:7)	37 (9:28)	34 (17:17)	39 (16:23)
Regraded (M:F)	5 (2:3)	8 (5:3)	13 (3:10)	7 (2:5)	12 (6:6)	8 (3:5)	6 (1:5)	14 (11:3)
Deaths (M:F)	64 (23:41)	75 (28:47)	44 (22:22)	65 (28:37)	64 (28:36)	66 (27:39)	57 (24:33)	53 (13*:40)
Total nos. leaving (M:F)	157 (64:93)	224 (91:133)	189 (76:510)	184 (80:104)	195 (90:105)	220 (83:137)	201 (79:122)	220 (85:135)
Average daily no. resident	787 (290:497)	791 (294:497)	800 (296:504)	807 (298:509)	841 (311:530)	869 (321:548)	877 (330:547)	892 (338:554)
No. days resident	288,404	289,873	292,986	297,614	310,351	317,898	322,153	326,792

* lowest death rate among the men for 25 years

Table LM-2: Table to show origin of Littlemore patients (indicated by the local authorities paying for their care):

Local authority	1923 – Men	1923 – Women	1923 – Total	1929 – Men	1929 – Women	1929 – Total	1935 – Men	1935 – Women	1935 – Total	1939 - Men	1939 - Women	1939 - Total
<i>County:</i>							155	223	378	180	251	431
Abingdon	3	5	8	2	4	6						
Banbury	29	40	69	28	37	65						
Bicester	5	15	20	12	22	34						
Chipping Norton	21	30	51	24	28	52						
Faringdon	1	5	6	1	3	6						
Headington	42	85	127	44	85	129						
Henley	9	24	33	10	17	27						
Oxford	41	39	80 = 13%	47	37	84 = 11%	83	112	195 = 24%	102	136	238 = 26%
Thame	13	10	23	12	14	26						
Wallingford	4	6	10	5	6	11						
Witney	24	29	53	18	35	53						
Woodstock	11	17	28	13	19	32						
<i>Out-county:</i>												
Various	1	2	2	-	3	3	3	9	12	5	4	9
<i>Contracts:</i>												
London	49	20	69	-	20	20	-	20	20	10	10	20
Middlesex				27	91	118	30	98	128	30	100	130
Croydon				19	20	39						
Nottingham				-	9	9	-	32	32	-	32	32
Buckinghamshire							10	20	30	-	30	30
East Ham							-	12	12			
Service Patients	23	-	23	20	-	20	20	-	20			
Private patients							1	1	2			
TOTALS	276	326	602	282	453	735	301	527	828	337	564	901

Table LM-3: Table to show breakdown of staff at the Littlemore Hospital.

Staff	1926/7	1927/8	1931/2	1937/8	1938/9
<i>Medical team (mental illness):</i>					
Medical Superintendent (MS)	1	1	1	1	
Assistant Medical Officer (AMO)	2	2	2	2	
Medical Student(s)					
<i>Nursing staff – Male Side</i>	47	46	50	65	65
Head male nurse	1	1	1	1	1
Assistant Head male nurse	1	1	1	1	1
Nurses – day	36	36	38	55	52
Nurses – night	9	9	10	8	11
<i>Nursing staff – Female Side:</i>	63	61	62	86	91
Matron	1	1	1	1	1
Assistant Matron	-	-	1	2	2
Nurses – day	52	49	49	72	71
Nurses – night	10	11	11	11	17
Total Nurses – day	88	86	89	130	
Total Nurses – night	19	20	21	19	
Total certificated or registered	41 = 38%	40 = 38%	49 = 45%	66% - M	50 – M
				18% - F	12 – F

Table LM-4: Table to show staff to patient ratios at the Littlemore:

	Nos. Patients	Nos. Nurses – day	Ratio Nurses: Patients
1926/7	667	88	1 : 7.5
1927/8	707	86	1 : 8
1931/2	787	89	1 : 9
1937/8	865	130	1 : 6.5 (NB new shift pattern)
1938/9	878		

Table LM-5: Table to show nurses' achievement of RMPA qualifications:

	Total Male Nurses	Male Nurses having passed Final exams	Male Nurses having passed Prelims	Total Female Nurses	Female Nurses having passed Final exams	Female Nurses having passed Prelims
1926/7	47	41	16	63	41	16
1927/8	46	24	11	61	24	11
1931/2	50	38	6	62	16	11
1934/5	65	40	1	?	20	11
1937/8	65	66%		86	18%	?
1938/9	?	52	7	91	12	25

Appendix iii:

Timeline – England and France 1870-1939

Date	England	France
1870-1		Franco-Prussian War, ending in French defeat and loss of Alsace Lorraine
1870		Third Republic established
1885	<i>The Handbook for the Instruction of Attendants on the Insane</i> first published by MPA	
1890	The Lunacy Act	
1891	First national training course in mental nursing established by MPA	
1892		Nursing School established at Ste Anne's
1893		Free Medical Assistance for Indigents
		Death of Jean-Martin Charcot (b.1825)
1894		Dreyfus Affair (1894-1906)
1899	Second Boer War (1899-1902)	
1901	Death of Queen Victoria; accession of Edward VII	
1903		Marie and Pierre Curie win Nobel Prize for Physics
1905		Law separating Church and State
1905		Law providing assistance for the elderly indigent
1906	Liberal Government: Series of Welfare Reforms	
1907		Every Seine asylum to have its own nursing school
1910	Death of Edward VII; accession of George V	Law to set retirement age of 65 years for workers
1911	National Insurance Act (contributory scheme of health insurance and limited unemployment benefit)	
1912	Post-graduate Diploma in Psychological Medicine established by MPA	<i>Manuel Technique de l'infirmier des établissements d'aliénés</i> by Drs Roget Mignot et Ludovic Marchand first published (became the "Bible" for French mental nurses)
1913	Mental Deficiency Act (separate care for the intellectually impaired)	
1914-18	World War I	World War I

1918	Epidemic of influenza (1918-19)	Epidemic of influenza (1918-19)
1919	Ministry of Health established General Nursing Council (GNC) established	Value of the Franc falls by c.50%
1920	GNC offers training for mental nurses	Law banning contraception
1920	Unemployment Insurance Act (expanded the provisions of the National Insurance Act of 1911)	Ministry of Health established
1921	Unemployment reaches 2.5 million	
1923	<i>The Handbook for Mental Nurses</i> (7 th edition of the original MPA handbook published under a new name)	
1923	Conservative Gov: Stanley Baldwin becomes PM	40,000 French troops occupy the Ruhr in failed attempt to force Germany to pay war reparations
1924	Labour Gov: Ramsay MacDonald becomes first Labour prime minister	Cartel des Gauches elected – moderate socialist coalition
1924-9	Conservative Gov: Stanley Baldwin becomes PM again	Gaston Doumergue elected as President (1924-31)
1924		National Office of Social Hygiene established in Paris (Rockefeller funding)
1924		New national mental nurse training course established (2 years)
1924		Devaluation of the franc (first)
1925	Britain returns to the gold standard	Georges Valois creates the fascist party, Le Faisceau
1926	General Strike	Poincaré returns as PM
1926	Medico-Psychological Association (MPA) becomes the Royal Medico-Psychological Association (RMPA)	
1927	Julius Walter-Jauregg wins Nobel Prize for malaria therapy	Julius Walter-Jauregg wins Nobel Prize for malaria therapy
1928	Women over 21 given the vote	Law on social insurance and maternity leave
1928	Alexander Fleming discovers penicillin	Devaluation of the franc (second)
1929	Labour Government: Ramsay MacDonald as PM	
1929	Wall Street Crash triggers the Great Depression	Wall Street Crash triggers the Great Depression
1930	Mental Treatment Act – provides for the voluntary admission of patients to public mental hospitals	New edition of <i>Manuel Technique de l'infirmier des établissements d'aliénés</i> published; new 5-year training course in mental nursing introduced but not widely taken up
1931	National Government Coalition formed	
1932	Unemployment peaks at just under 3 million	

1932	Oswald Mosley founds the British Union of Fascists	Law regarding the institution of “allocations familiales”
1933	Adolf Hitler becomes Chancellor of Germany	Adolf Hitler becomes Chancellor of Germany
1935	Conservative Government: Stanley Baldwin as PM for third time	
1936	Jarrow March	Election of the radical leftist Popular Front, with Léon Blum as PM
1936	Death of George V Accession and abdication of Edward VIII	Law regarding paid holidays Law regarding 40-hour week Schooling until age 14 years becomes obligatory
1937	Accession of George VI	Asylums become known as “psychiatric hospitals”
1938		Devaluation of the franc (third)
		General strike
1939	Start of World War II	Start of World War II