A history of Lancaster Moor Hospital

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INTRODUCTION

This account of the history of Lancaster Moor will focus on what I find remarkable and interesting or connected with my medical speciality. A much more systematic, well-researched and academic history is overdue and could draw on oral accounts from staff who worked there from the 1960s, or even the 1950s, onwards.

The Lancashire County Lunatic Asylum (later Lancaster County Mental Hospital, and, in 1948, Lancaster Moor Hospital) was opened in 1816. It was the fourth county asylum nationally; therefore one of the very earliest. In 1808, the passing of the Lunacy Act allowed local magistrates to fund the care of pauper lunatics from the rates; many hitherto had been housed in workhouses or, those who could pay, in privately run madhouses. Asylum building took place throughout the UK, Europe and America, especially from 1840 onwards into the first decade of the 20th century. The earliest asylums, like Lancaster, were built to look like pleasant country estates. They were outside centres of population necessarily, to give space for fresh air and exercise and to remove the patients (sometimes called inmates) from overcrowding and the insanitary conditions and infectious diseases found in towns and cities. The word asylum, of course, had its positive meaning at that time of 'safe retreat'. The development of asylums represents one of the great humanitarian advances of the Victorian era. The ideology was that the insane needed good food, exercise, fresh air, pleasant surroundings and occupation, and that the care should be founded on forbearing kindness and humanity. Abuses in private madhouses, excessive use of restraints and total lack of success in treating insanity by physical treatment (such as cupping, leaching, water baths, etc) led to these ideas of moral treatment first advocated by Tuke in York, and Pinel in France.

FIRST PERIOD: 1816-1883

The Lancashire Asylum was very much part of this ideology as soon as Samuel Gaskell became medical superintendent. He recorded in his 1841 report to the visiting magistrates his abandonment of such restraints as hand-cuffs, leg locks, and straight waist-coats. He had also found 30-40 patients 'who were chained down during the day time on seats so constructed as to answer all the purposes of water closets.'[1] He informed the inspectors in 1842 that inmates would neither be required to work nor punished if they shirked;[2] this was to emphasise that work was therapeutic, unlike the situation in workhouses at the time where work was compulsory. He instituted regular toileting during the night for incontinent patients, which reduced the filth and stench of the wards and also ensured that the night attendants were awake and active. His innovative methods of asylum management became well known, nationally and internationally: he was later appointed FRCS and Commissioner in Lunacy in 1845. The Commissioners oversaw the management of the asylums generally. He organised a group of asylum doctors into a medical society which was later, eventually, transformed in the Royal College of Psychiatrists.[3]

The attractive original building and gracious landscaping of Lancaster Moor Hospital, now residential accommodation

SECOND PERIOD: 1883-1930

Other asylums in Lancashire were built at Prestwich, Rainhill and Whittingham, the numbers requiring asylum care relentlessly rising throughout the 19th century. In Lancaster, the Annexe opened offering places for an extra 825 patients in 1883. This colossal building in red sandstone, described by Pevsner in The Buildings of England as a 'serious, matter-of fact piece of work',[4] is best seen from the top of the hill on the back road to Caton. The character of asylum buildings had by that time changed from country house style to institutional style. The asylum, not yet a hospital, was a world in itself with farms, piggeries, gardens, greenhouses, joinery shop, kitchens, upholsterers, sewing room, laundry and other areas which provided work for inmates (not yet patients). Male and female inmates and attendants (not yet nurses) were rigidly separated. There was a hospital library and a theatre with stage and grand piano, and 600 patients might attend morning and evening service at St Michael's Church (opened in 1866).

Dr Cassidy was medical superintendent for 50 years (1876-1926). In 1900, he led a deputation to see the design of buildings of continental asylums, and he adopted the idea of

1926: Rolleston Report
The Home Office opposed the treatment of addiction to a dangerous drug by the prescribing of 'maintenance' doses, or gradual reduction and considered that sudden total withdrawal was the only way in which addiction could be managed. Rolleston opposed this dogma as impracticable and recommended that doctors could be allowed to prescribe reducing doses or, in extreme cases, maintenance.

1928: Dangerous Drugs Act amended
Cannabis (plant material, resin and oil) added to the Act's list of substances and introduces the offence of the possession of cannabis.

1931: Narcotic Drugs Convention Geneva
Signatory countries were required to produce detailed drug consumption statistics, and production of 'narcotics' was limited to quantities required in medicine and research. The detail introduced the drug 'Schedule' system in common use to this day.

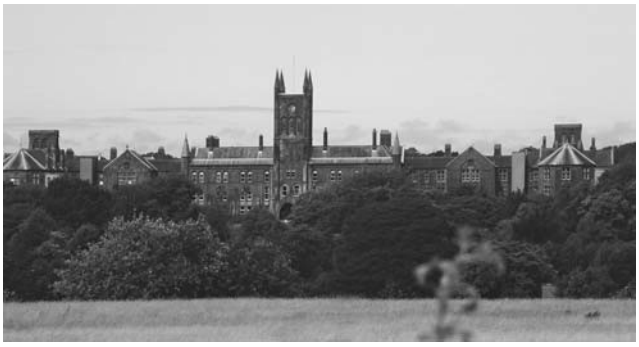
small annexes housing 24-40 patients set within the grounds of the main building.[5] These were to be more homely and more like normal living, allow matching of patients and give attendants more personal interest in their patients. Outlying buildings, later called after Drs de Vitre, Gaskell, Campbell, Cassidy and others, were built at this time. The Commissioner's Report of 1889 noted that the first telephone, 'which placed the asylum in communication with many of the large towns of Lancashire', had been brought into use.[6] Dr Cassidy was trying massage and Turkish baths for melancholia. The Commisioners were critical that on Ward 14 there were only two water closets, five basins and one bath for 93 female patients. Also, that there was no detatched building for contagious diseases.

Low staffing levels and large numbers of patients and lack of success in curing insanity made it difficult to continue with moral treatment. Asylum doctors had not been able to discover the causes of insanity by the usual pathological methods of post-mortem examination and histopathology of the brain. Physical treatments were tried again, such as bromides, chloral hydrate, paraldehyde and other sedatives. They proved useful in cases of prolonged acute excitement to prevent death by exhaustion. The Lancashire asylum was known, however, to have good rates of recovery and discharge: for instance in 1889, there were 586 admissions and 170 patients discharged, recovered or relieved.

THIRD PERIOD: 1930-1948 (LANCASTER COUNTY MENTAL HOSPITAL)

The asylums became hospitals after the passing of the Mental Treatment Act in 1930 which allowed for informal voluntary admission. Some wards were unlocked and patients given parole; outpatient clinics started allowing earlier discharge.

Dr Silverston (who was known to do his ward rounds on horseback) became medical superintendent in 1937 and drew attention to the age and run-down state of the buildings.[7] He reported no new building and no adequate maintenance of existing buildings from 1915 to 1937. He noted no proper admission unit, no occupational therapy building, no female sick ward, the poverty-stricken appearance of the furniture on the wards and multiple structural defects of the buildings. The old side-heating system, which had been installed during 1840 to 1890, lost 50% of the heated steam in the supply pipes. The hot water system, installed in 1907, was able to supply 'indifferent quantities of luke warm water to the lower floors.' Some wards were still locked and the locks on the old side were anything up to 130 years old, requiring ponderous iron keys which resembled heavy engineering tools. A full-time locksmith was required to cope with misuse of keys and breakages. However, Dr Silverston records with satisfaction that the acid test of a hospital's efficiency is shown by the ratio of discharges to admissions and that Lancaster's ratio was very much higher than the country's average. He and his engineer drew up elaborate plans for the improvement of the buildings and new departments, but these were forestalled by the outbreak of the Second World War.



The Annexe. This still exists but is now essentially mothballed

FOURTH PERIOD: 1948-1980 (LANCASTER MOOR HOSPITAL)

In 1948, mental and sub-normality hospitals were taken into the NHS at the last minute, against some previous recommendations. Lancaster Moor, unlike Royal Lancaster Infirmary (RLI) for instance, had been a publicly funded institution for well over 100 years. However, the mental hospitals were disregarded and underfunded, and became 'Cinderella services'. Amazingly, the workhouses still contained mentally enfeebled and sub-normal residents in large numbers when they closed in the same year.

Voluntary admission became the 'norm' after the 1959 Mental Health Act, with increasing admission numbers and chronic elderly patients surviving longer and longer. Alternatives to the need for residential care in hospital were urgently sought and day hospitals, boarding-out schemes, and rehabilitation were developed. The special profession of psychiatric social work became increasingly important and Lancaster Moor benefited enormously from its on-site social work department, which lasted until the mid 1990s. Patients were boarded out with chosen landladies in Morecambe and their care was supervised by hospital staff, and most returned by hospital transport to work daily in the hospital, at Standen Enterprises or the occupational therapy department. Rehabilitation wards and staffed hostels in the community were developed. This was a period of optimism and achievement, accompanied by advances in the pharmacological treatment of mental illness. Lancaster Moor had two units of regional significance: an inpatient child psychiatric unit, with consultant, teaching staff and specialist occupational therapy; and the alcohol treatment unit. Consultant staff in sub-specialities, such as alcohol treatment, rehabilitation and old-age psychiatry, were appointed.

Meanwhile, the number of residents had been reducing year on year from a maximum of 3,200 in 1940, when the hospital

1932: Benzedrine
Amphetamine is marketed as Benzedrine in an over-the-counter inhaler to treat nasal congestion.

1933: Pharmacy and Poisons Act
The development of potent medicines, including barbiturates and digitalis, resulted in revision to poisons legislation. The new Fourth Schedule listed poisons that required a prescription given by a doctor, dentist or veterinary surgeon – a major increase in the medical profession's control of the supply of drugs.

1938: Food and Drug Act
Now illegal for a person to sell a drug labelled in a misleading way. It also became an offence to publish an advertisement which did so.

1938: LSD
Albert Hofmann synthesised lysergic acid diethylamide (LSD) as part of a programme of research into potentially useful ergot alkaloid derivatives. Five years later, accidentally

had cared for mentally ill service personnel. By the mid-fifties, large areas of the hospital were empty.

It was decided by the hospital management committee that Lancaster Moor could be developed into a 'comprehensive hospital' where the nursing and medical care of the acute sick, chronic sick and mentally ill could be carried out on one site and mostly under one roof.[8] The Garnett Clinic at the south end of the Annexe building opened in 1958; the orthopaedic department at RLI had special need for extra ward space for rehabilitating patients who had previously been cared for at St John of God in Silverdale or Meathop Hospital. The first hip replacement operation in Lancaster took place at the Garnett Clinic using extremely innovative methods of air filtration to exclude infection. Ophthalmology wards arrived, also post-acute medical wards, surgery and neurosurgery. Geriatric medicine occupied outlying buildings from 1960 onwards, with Hornby House converted in 1973 into a geriatric rehabilitation unit with 38 residential and day places. Departments of pathology and psysiotherapy, a pharmacy, a school of nursing, a school of radiology, and EEG were on site, together with a subregional blood transfusion unit. The hospital had its own fire station (until 1957), its own post office and the main local mortuary (until 1987).

The 150th anniversary report says that 'the use that has been made of an old mental hospital in which considerable improvements and renovations have taken place, is unique in this country.'[8]

FIFTH PERIOD: 1980 ONWARDS (AND THE RUN DOWN OF LANCASTER MOOR HOSPITAL)

The Hospital Advisory Service (HAS) paper The Rising Tide[9] drew attention to the increase in prevalence of dementia owing to increasing longevity and also to the special features of mental illness onsetting after the age of 65. It outlined the services and residential places likely to be needed for this group. Lancaster Moor was in a good position to meet this need and was able to offer assessment wards, urgent or planned respite care, continuing care, inpatient rehabilitation and day hospital with another day hospital (Morecambe). A team of psychiatric community nurses was set up (later it became a multidisciplinary community team) and our organic assessment unit moved into the Medical Unit for the Elderly at RLI as recommended in the HAS report.

While psychogeriatric services were developing, large numbers of psychiatric patients originating from other parts of Lancashire were transferred to their home areas. This was a painful time for staff as long-standing and familiar patients were transferred away. Admission wards at Ridge Lea were vacated when Blackpool and Kendal opened psychiatric admission wards in their general hospitals, and a psychogeriatric assessment unit and a locked ward for disturbed patients moved across to Ridge Lea, further emptying the Annexe building. The department of geriatric medicine transferred to the RLI site when the Medical Unit for the Elderly was built in 1984, and the Garnett Clinic closed in 1996. The children's psychiatric unit and the alcohol treatment unit moved to sites in Lancaster in the mid-nineties and the old side closed completely in 1998. Eventually, the long-planned community units for the elderly mentally ill were built, one in Lancaster, one in Morecambe and one in Heysham, and their opening allowed the final closure of Lancaster Moor Hospital in 2000. *Sic transit gloria…*

CONCLUSION

Lancaster, as county town, developed two very important institutions, both in the forefront of national trends – the Asylum in 1816, and the Royal Albert Hospital in 1863. Such institutions have, of course, had their day. The people associated with them have played an important part in the life of the city and the citizens have supported them by public, and later state, funding.

It is perhaps fitting that this historical review has been prepared in the year that Dr Stanley Smith MD, MRCP, FRCPsych, the last Medical Superintendent, died aged 90; we are awaiting his obituary, which is being prepared jointly by the Colleges of Psychiatrists and Physicians.

ADDENDA

The Lancaster Moor community spirit

The hospital was a very significant local employer, well known for its friendships and community spirit. A large part of the population of patients and staff was relatively stable and many of the nurses trained there and spent their working lives on that site; some indeed had parents and other close relatives who worked there. My longest-stay patient was admitted as a child in 1905! The nursing staff supervised patients at daily evening entertainment such as film shows, spelling Bs, and dances at Standen Hall, and put on concerts and pantomimes themselves. There were special officers for the programme of activities and entertainments, and others to organise volunteers to support functions. At Christmas, every ward had its ward party with decorations, Christmas tree and chaplains' visits, and patients wore their best clothes. A regular newsletter, *Moor News*, was printed in the hospital; it records that in 1970 the annual ball put on for the staff at the Ashton Hall was attended by 800 people! The hospital had its own football, cricket and rugby teams (and pitches) and played in the local leagues. The patients were onlookers at matches, and some were involved with maintenance of ground and equipment; one patient looked after the cricket boots for years.

A very important contributor to the community spirit was the staff social club, on-site and near the bowling greens. This club

absorbing a small amount through his skin, he discovered the psychoactive effects.

1942: methadone
The opiate drug later named methadone is patented.

1947: Penicillin Act
Antibiotics now recognised as substances 'capable of causing danger to the health of the community if used without proper safeguards', and distribution limited by prescription.

1948: Paris Protocol
The 'similarity concept' introduced into drug legislation in order to prevent drug manufacturers evading legislation by producing analogues of prohibited drugs.

1956: Home Office advice
Doctors were reminded of their obligations and of the limitation of their authority to possess and supply dangerous drugs. A practitioner could do so only 'so far as may be

had its own football, cricket, bowls, golf, badminton and fishing clubs, and latterly organised regular events and dancing for people with learning difficulties. The club was open daily, was well patronised, and did not finally close till 2009.

My career at Lancaster Moor

I started as a clinical assistant in 1969 at a salary of £3. 10s. a session, which did not cover the babysitting. I was responsible for the physical care of longstay patients and their annual physical examinations. I gained a Diploma of Psychological Medicine by correspondence course and saw such outmoded procedures as ECT given straight, insulin coma for anorexia, fits induced by CO_2, continuous narcosis, paraldehyde by mouth or rectum, and anafranil by drip. But enough of that! The ideas deriving from the anti-psychiatry movement (The Myth of Mental Illness by Thomas Szasz, One Flew Over the Cuckoo's Nest, etc) blew in a refreshing change. Nurses, clinical psychologists and doctors became more interested in psychological and talk therapies; we ran outpatient groups for obsessional and phobic disorders. We set up a modified therapeutic community on an admission ward where the patients worked together cleaning the ward and cooking their own meals; the nurses ate with the patients and it was christian names all round. The morning meeting was attended by all patients, nurses, medical and portering staff to discuss plans for the day and what had already taken place: criticism and reality confrontation was normal. Labelling a patient with a diagnosis was not done!

After I qualified with MRCPsych, I obtained a consultant post in general adult and old age psychiatry which I held from 1983-2006. It was an extremely rewarding time to be in this actively evolving subspeciality, and the current topical and press interest in memory disorders testifies to the importance of the role of mental health professionals in the modern NHS.

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Photographs by the author.

This coat of arms is on a wall in the Annexe of Lancaster Moor Hospital.

If you know what the cockerel represents and/or can explain the symbols please contact the *Journal*. The Editor, Morecambe Bay Medical Journal, Education Centre, RLI, LA1 4RP.

necessary for the practice or exercise of his profession.' There had been cases in which doctors and dentists had been convicted of offences under the dangerous drugs legislation for diverting prescribed drugs 'to the gratification of their own addiction'.

1961: United Nations Single Convention on Narcotic Drugs
All the earlier agreements governing the control of narcotic substances (including opiates, cocaine, cannabis and cannabis resin, but not lysergide (LSD) or amphetamines), replaced. Over 100 drugs are covered by the legislation and covered in four 'schedules'.

1961: first Brain Committee
The use of dangerous drugs for the treatment of addiction reviewed. Reported in favour of the status quo, and concluded that further restrictions on heroin and cocaine were not necessary.