INTERVIEW

Kathleen Jones

In conversation with Peter Kennedy

Professor Kathleen Jones, born 1922, was educated at the North London Collegiate School and Westfield College, University of London (in Oxford). She worked in WEA and Extra-Mural teaching from 1943–5, and went to the University of Manchester after a career break in 1951. She lectured in Social Administration until 1965, when she became Professor of Social Policy in the University of York, a post which she held until 1987. She has travelled widely, to most countries in Europe, to North and Central America, to Russia, to China, to Malaysia, to the Middle East, mainly in the interests of mental health research. She is the author of some fourteen books, and numerous reports, papers and articles. She now lives in York, and continues to write, with the aid of two computers.

One of the striking things is how difficult it is to categorise your career.

I know, I don't envy you the task. It will not categorise in professional terms. Perhaps it is a one off – it could only have happened in England, in that particular period of time.

It started with reading History at university?

Yes. University of London evacuated to Oxford during the Second World War. I joined the Oxford Democratic Socialists. We were all tremendously concerned about social reform – wanting to build a better Britain after the war. When I graduated, I got a job as a full-time lecturer for the Workers' Educational Association, with some university extramural classes. I gave nine lectures a week, up and down the south coast.

On what subject?

"Britain – what next?" "Germany – what next?" "Russia – what next?" I have never been able to see a cut-off point between 'history' and current events. At 22, I could lecture on almost anything. I am a bit more cautious these days.

When did your interest in mental health begin?

After the war, when I got married. My husband, Gwyn, was related to Rolf Ström-Olsen, who was the medical superintendent of Runwell. We used to go and stay at Runwell, which was the only new mental hospital built after the 1914–1918 war. Rolf was not much over 30 when he was appointed, and he was an enthusiast. We learned all about the villa-system, and new ideas in patient care. Gwyn was an army chaplain. When he finally got out of the army, we both decided that we might do something useful in a mental hospital setting, so we went to Winwick, in Lancashire.

What was it like?

It was a huge hospital of over 3000 beds, like a small town. It had its own fire-engine and its own farm. It was very hierarchical. The medical superintendent had the largest house, with a long corridor connecting it to his office, so that he need not talk to anyone on the way. We had the next largest house, because under the 1890 Lunacy Act, the chaplain was designated as the second officer of the hospital. The salary did not match the status – we could not even afford to curtain all the windows. Then came the Residences: for the deputy medical superintendent, the hospital secretary (who had not yet given himself a grander title) and the engineer. After that, the Villas came next in the pecking order, then the Houses; and the patients came last. That worried us.

What did you do at Winwick?

We got involved in the mental health movement. The medical superintendent was Dr Ernest Nicole (inevitably known in the hospital as 'Old Nick'). He was very progressive for the time. Everything was therapy. We had music therapy, sports therapy, education therapy, work therapy, social therapy. Nick was an agnostic, but he used to join

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in 'hymn-singing therapy' with gusto. He set us to work taking parties round the hospital: medical students, JPs, social workers, teachers, and so on. And we both gave outside lectures on mental health to anyone who would listen. The Feversham Report of 1939 had recommended public education programmes to get rid of the stigma attached to mental hospitals. And the stigma was real enough. Winwick was five miles outside Warrington, and the bus conductors used to say "A return ticket to Winwick, luv? That's a one-way trip".

Your career as an author started about that time. You wrote a book, Lunacy, Law and Conscience. *That was your doctorate. How did it happen?*

Married women with young children did not work in those days. I wanted to read up the history of mental hospitals, and I found that very little had been written. I started with a short article, and that grew into an MA project, and then into a doctorate.

Who helped you with that?

When my son was old enough to go to school, the University of Manchester gave me a research assistant's post; and I owe a good deal to Dr Alexander Walk, who was for many years librarian of the Royal Medico-Psychological Association (RMPA). The RMPA was the precursor of the present Royal College of Psychiatrists. Alexander Walk knew far more about the history of mental hospitals than I shall ever know, but he did not write easily, and he encouraged me to do it.

How was the book received?

Quite well, because there was really nothing else on the subject. About five years after it was published, I went into a medical library and asked for Daniel Hack Tuke's *History of the Insane in the British Isles*, published in 1882. The librarian said "Oh, we've thrown that out now. There's a new book by somebody called Jones".

I'm very interested in the 'conscience' bit of your title. Can you say more about that?

Reforms in the 19th century asylums came about because people like the Tukes of York and Lord Shaftesbury appealed to the consciences of Parliament and the nation; and it worked. I doubt if it could happen now.

That sounds as though you are worried about the ethics of present mental health policy?

I am extremely worried about the ethics of present mental health policy. In recent years, the problems have simply been swept under the carpet, and administrators like you have been left to deal with them without the resources you need.

So you went on being interested in current problems, as well as in the history of the subject?

Yes. I lectured at the University of Manchester in social administration, and then moved to York in 1965 to start the new Department of Social Policy and Social Work. Nearly all my own research was in the mental health field.

I understand that, when Enoch Powell made his famous 'Water Tower' speech in 1961, you were very much quoted as a defender of the mental hospital system. Is that fair?

No, it is not fair. I was present when Powell made his speech. He was determined, as Minister of Health, to cut public sector spending, and I thought that the Government had no intention of introducing a good community care service. I had just finished writing up a research project, later published as *Mental Hospitals At Work*, and I prefaced it with twelve reasons why he was wrong. Most of those reasons still hold.

What were they?

It would take too long to spell them out now; but the chief reason was that in organisational terms, dispersal is always more expensive than concentration. If the government was not prepared to invest the necessary resources in training, research and community centres, the result had to be a decline in the quality of service.

In 1976, you became an Honorary Fellow of the Royal College of Psychiatrists. What did that mean to you?

I was very much honoured. Dr Walk sat in the front row, beaming, and said to me afterwards "I'm as pleased as if you were my own daughter". When I started work, psychiatrists and social scientists often collaborated in studying mental health systems – writers like Stanton and Schwarz, or John and Elaine Cummings in the States, and Maxwell Jones and Robert Rapoport over here. Now, of course, the two disciplines have moved apart. I have tried to repay my honorary fellowship by keeping them in some sort of contact with each other.

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When the 1983 Mental Health Act came into force, you became chairman of the regional Mental Health Act Commission. What was your view of how the 1983 Act worked out?

The Mental Health Act Commission was one of the few good things in a bad Act. The Act itself is highly legalistic, and concentrates almost entirely on the civil rights of the very few patients who are admitted to hospital under compulsory orders. It goes back to the philosophy of 1890. The Mental Health Act of 1959, which it replaced, was an enabling Act, which gave psychiatrists far more discretion.

Now there are proposals for further legislation, providing for compulsory supervision orders in the community.

I do not like the prospect of compulsory supervision orders, and I doubt if they are workable.

When the Mental Health Commission started work, there were very great tensions between psychiatrists and social workers. Do you think they have been resolved?

No. I think they have probably got worse, if anything; but we did not experience these tensions on the Commission, though everybody expected them. The Region elected me as chairman for the simple reason that I was not identified with any of the professional groups – psychiatrists, other medical practitioners, lay administrators, psychologists, nurses, lawyers. They thought they were going to fight, so I was appointed the arbiter. In the event, they didn't fight. They got on very well, and learned from one another. Cooperation is possible when professionals work closely together, but the present split between health and social services drives them apart.

How did you react to the anti-psychiatry movement?

I thought it was a combination of Conservative economics and Marxist rhetoric. Basically, it was another example of stigma. The Conservatives didn't want to pay for good mental health services, and the Marxists saw mental hospitals as Bastilles to be knocked down. Everybody read Laing and Szasz and Foucault. Of course, Laing and Foucault were politically on the extreme Left, and Szasz was on the extreme Right, but few people read their books carefully enough to find that out.

You were impressed by the American community mental health centre (CMHC) movement. Why?

CMHCs are the only example of an attempt to replace the services which mental hospitals used to offer. They started in the Kennedy–Johnson era, in the 1960s. The best of them were very well-staffed, and well-funded. They were genuinely inter-professional. They offered a wide range of services: for adolescents, old people, drug abusers, rape victims, and patients' relatives. They developed public education programmes, housing programmes, group therapy, psycho-drama, storefront psychiatry, street psychiatry with the gangs. It was exciting and stimulating, a great contrast to the lacklustre services in Britain; but of course it did not last.

One of the common criticisms is that CHMCs did not meet the needs of the severely mentally ill, the psychotic patients.

I think they did. It was odd to find people like Dr Szasz championing the chronic patients. If mental illness is only a myth, presumably there are no chronic patients. But I sat in clinic sessions in the really sleazy parts of New York, where they provided me with a burly psychiatrist on one side and a burly male nurse on the other when I walked the streets; and in clinics in Washington, DC, which has more than its share of psychotic patients because of the proximity to the White House and the Capitol; and in rural Florida – not the holiday coast, but 'alligator country', where the red-necks live. I think the services really reached the people who needed them most.

So what killed the movement off?

Funding began to run out when federal pump-priming stopped, and the costs fell on state budgets. Interprofessional cooperation got out of hand. Social workers and occupational therapists began to say "We know as much as the doctors – why can't we prescribe?". And psychiatrists in private practice were losing patients. In one city, I saw them organise a movement to drive the CMHC out of town. Its lease was mysteriously terminated, and the managers could not find other premises. Public meetings were organised: little old ladies with blue hair and sausage curls got up and said "We don't want all those crazies around here", and big tough lorry drivers hitched up their trousers and said "Get those crazies outa town". Eventually the CMHC was housed out on the ring road, where the most seriously ill patients could not reach it because there was no public transport.

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It was in the mid-1980s that you decided to make a visit to Italy. Did you not go down the whole spine of Italy?

That's right, from Como to Reggio di Calabria, to study 'the Italian Experience'. MIND had publicised this widely, asking "If Italy can get rid of its mental hospitals, why can't Britain?" Most of the writers on the subject seemed to have based their articles on three days in Trieste, which is hardly 'Italy'. I knew Italy fairly well. It is a beautiful country for a holiday, but the public services are somewhat disorganised. I thought that if we could not run a decent community care service, it was unlikely that the Italians could. I do not speak Italian, so I found an interpreter, Alison Poletti, who became very involved, and ended by being my collaborator. We simply drew a line down the map of Italy, and visited psychiatric facilities all the way. The trip gave us both nightmares for months. The services were poor in the north, and appalling in the south. I still wake up at night and think of those patients, just sitting on benches doing nothing, while the hospitals fall down around them because there is no administration and no maintenance any longer.

There were still mental hospitals?

The hospitals were still there, but the people in them were called 'guests' – a nice euphemism. They were allowed to stay because they had nowhere else to go; and new 'guests' were still being admitted. It was illegal, but who cared? Italians do not have that much respect for the law. I remember in particular one hospital south of Naples. The buildings looked all right from the road, but when we asked for the psychiatric unit, there were nods and laughs and winks. We were told it was right down at the back. The psychiatric unit is always right down at the back. We went past absolute squalor, where slavering dogs with their ribs sticking out were scavenging in dustbins, to a huge and apparently empty building. There was nobody about. There were great holes where the doors and windows had been taken out and not replaced, and bare electric flexes hanging from the ceiling. The walls were bare, and there was no furniture. We found out later that the unit was about to be upgraded in 1978, but when the new law came into force, the workmen had been withdrawn. After a time, we heard a dreadful groaning and moaning coming from the top of a flight of steps. We went up, and found 60 women behind iron bars. The bars were there to stop them falling down the stairs; they never went out, because there were not enough staff to look after them. The doctor in charge was an absolute hero – he really cared for his patients; but he had only two nurses per shift. They were untrained, and there were no orderlies, so they spent most of their time mopping up after the patients, changing sheets and giving out medicines. They had no furniture except iron beds, no chairs, no tables, no flowers, no pictures. Some of the women walked about, wrapped in shawls, muttering. Others sat on the floor, banging their heads against the wall. There were no community services at all. The doctor dreamed of a little unit with ten or twelve beds, where some of his patients could learn to cook and do simple household tasks; but he did not think it would ever happen.

Yet the policy had been running for some years, and internationally, it was regarded as a great success?

That was because other people who had reported on it had only been to Trieste. We ran into massive criticism, largely on the grounds that we had not been to Trieste. So in the following year, with the help of a British Academy grant, we went back to Italy. Trieste had an excellent service, based on drop-in centres or therapeutic social clubs. People went when they liked, and stayed as long as they liked. There were group sessions and individual therapy, and a good domiciliary service in times of crisis; and there was a real warmth of human contact, even for foreign visitors. When we left, a woman patient came out on to the verandah and bawled, because we were leaving. But Trieste is not Italy. It used to be part of the Austro-Hungarian Empire, and it is geographically cut off from the rest of Italy. It had – and probably still has – a Communist regional government which provided generous funding for a model service. And it had a charismatic founder, Franco Basaglia. But you cannot run a good service without good funding; and you cannot run a genius-system without a genius.

A genius-system?

I thing the term is Max Weber's. It means an organisational system which depends on one charismatic person who can galvanise everybody else, and keep them moving. Most of the mental health systems which are reported as successes are genius-systems. That is why they are so difficult to replicate.

In your travels round the world, have you seen any services that are good models?

Sadly, no. The fashion of running down mental hospitals has swept round the world. People are worried about it in Australia, in New Zealand, in

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Canada, in a dozen other countries, but it seems unstoppable. It saves money, and everybody is very cost-conscious. Governments do not know what the effects are, because they will not pay for the research to find out.

Can I move on to another aspect of your career? You were invited to join Lord Gardiner's Committee on Terrorism and Human Rights in Northern Ireland in the mid-1970s. How did you get into that?

I was invited by the Secretary of State. My own theory is that my name came up because I have an Irish first name and a Welsh surname, though in fact I am solid English! There were seven of us on the committee, and I was the only woman. I think we did a good job. We met for three days a week in Northern Ireland for about six months. It was hard work, because I was running a university department at the same time. We had to travel by a different route each time for security reasons. Security in Northern Ireland was quite tight then. We went into the Maze prison, and talked to prisoners on both sides. At that time, the Maze consisted of Nissen huts in compounds separated by barbed wire, and the prisoners ran the compounds themselves, drilling all day long with broomsticks instead of rifles. Republicans and Loyalists were separated, of course. We had to go to the compound gate in each case, and ask the Number One very nicely if we might come in. They were actually very hospitable, and talked quite freely. We also interviewed everybody who wanted to be interviewed, including the Rev. Ian Paisley and the representatives of Sinn Féin.

Was it worthwhile?

Yes, I think so. We could not bring immediate peace to Northern Ireland, but we recommended the end of detention without trial, and that took place almost immediately. We recommended that a new Maze prison should be constructed, with cells, to put an end to what the Press called "a school for terrorists". We fought very hard to restore trial by jury – that was not implemented because juries were being intimidated; and we insisted on keeping the right to silence, against official invitations to abolish it. The present Home Secretary has now abolished the right to silence. I remember arguing that it had a very good precedent: Christ kept silent before Pilate.

That brings me to another very important part of your career: the part you played in the Anglican church. You were on the General Synod of the Church of England for some years; what was that like?

A talking-shop. There are too many characters airing their egos. I was quite glad to get off again.

And you were a member of the Archbishops' Commission on Church and State?

Yes, that was from 1970 to 1975. We had a very interesting remit: to undo Henry VIII's Act of Supremacy, which placed all power in the Church in the hands of the state. We were trying to give the Church of England more freedom from state control, and to bring the Roman Catholic Church and the Free Churches, all of whom sent observers, into closer relation with it.

Where has that led?

The Church now has a greater voice in the appointment of its own bishops; and I think the churches have moved closer together. I liked the Prince of Wales's statement that, if and when he was crowned, he would prefer to be recognised as the Defender of Faith – rather than the Defender of *the* Faith, that is, the established Church.

Your recent book Asylums and After *tells a story going back over 200 years, which many psychiatrists may not know, and seems to bear out the saying that if you do not know your history, you are doomed to repeat it. Are we repeating things which happened in past decades or centuries, that we ought to know about?*

It is not exact repetition, because the whole psychiatric system has moved out of the institution into the community. What does recur sickeningly is the frustration of good ideas and good programmes by public authorities who think mentally ill people are not worth spending money on. We build new prisons and new sport centres and new leisure centres, but mental illness comes a long way down the list of priorities. I do not think most psychiatrists have yet come to terms with what the move to the community means. Their specialised infrastructure has gone. Now they are out in the jungle, a professional jungle for them, and a hostile environment for many of their patients.

How are psychiatrists meeting the challenge?

Most of them are not meeting it at all. They are clinging to their status as members of a hospital and clinic-based profession. I argued in my Maudsley Lecture in 1978 that psychiatrists

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needed to keep one foot in medicine and plant the other firmly in the social sciences. Medicine provides their power-base, but the social sciences are increasingly relevant to their knowledge-base. How can they practise community medicine if they do not know how some of their patients live, i.e. what it means to be unemployed, to have your windows smashed by the local kids because you are 'barmy', to be afraid to walk the streets?

But you have some sympathy for psychiatrists?

Psychiatry is a very difficult area to work in: I once said in a lecture that psychiatrists shared with social workers and clergy and meteorologists the knowledge that most of their work was going to look like failure; but it is still worth doing.

What are you doing now?

I am currently writing about saints.

Saints?

I am revising and re-editing (which means largely rewriting) a volume of Butler's *Lives of the Saints*, a standard work first published in 1756. I have 201 saints to write about. A Catholic friend in the United States wrote and said that she was sure that my saints were all looking after me. I hope so. I want to take out all the pious sentimentality, which really does them a disservice, and simply to show them as people who tried to live according to their faith. Among my 201 are St Francis Xavier, St John of the Cross and St John the Evangelist – remarkable people.

You translated St John of the Cross?

I translated the *Poems*. That was a separate exercise. I learned Spanish in order to do that.

How old were you when you learned Spanish?

I was 68.

What are the things you look back on with the most satisfaction?

My family life most of all. In professional terms, founding the Department at York, the Archbishops' Commission, Lord Gardiner's Committee, and of course the mental health books, which have gone on accumulating over the years. If I had been born 30 or 40 years later, I suppose I might have become a psychiatrist or a woman priest or a social worker; but I would probably have ended up in a university, writing books, anyway; and the mix makes sense to me.

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