| Interviewee: Ian Boddy (IB) | Interviewer: Margaret Smith (MS) |
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MS: Ian is going to primarily talk about his experiences and memories of working at the Crichton Royal Hospital, in Dumfries, here. So, Ian, maybe you could say a bit: where you were born and your early life?

IB: I was born quite a long way away from Dumfries. I was born in Bradford, in West Yorkshire, where my Dad was in the wool industry and my mother was a pharmacist. The wool industry in Bradford started to go into recession round about the late '50s, the early 60s, and the family decided, in 1962, to relocate to Paisley, in Scotland, just outside Glasgow. So we moved the family, that was my Mum, Dad and my sister Joanna, we left behind Bradford, all of our family and went to live in Paisley which was a bit of an unknown context because we had some vague kind of Scottish roots, through my dad's family, but that was the only thing that we had, which was across in the east coast. So I was in Paisley from 1963 onwards where I went through my schooling and I left at eighteen with a handful of Highers and went off to the University of Stirling. My family, at that point, were mainly all involved, to some degree, in the delivery of some kind of health or social care. My mum was the hospital pharmacist at Dykebar Hospital which was a psychiatric unit up in Paisley and as a result of that, when I was at school, I spent summer holidays working as a nursing assistant at both Dykebar and Riccartsbar Hospitals, which were both still known then as asylums. My dad had worked in the wool industry until he was made redundant and he finished up working as a Housing Officer for local authority, predominantly working with some of the very vulnerable people in housing estates and schemes round about Paisley. My sister is a couple of years older than me and she had gone off to Stirling two years before me and finished up being trained as a Social Worker and she finished up working as a Psychiatric Social Worker, so most of the family, all four of us had a degree of involvement in mental health care. I went to Stirling, at eighteen, to study Sociology and Psychology, which I managed to do for three years, I managed to come away from University of Stirling without a degree because I kept failing my Psychology exams. The result of that kind of failure was that I needed to do something which would win me favour back in the family's eyes, I think they thought I was a bit of a drop-out at the time. so I went back to the psychiatric hospital in Paisley, at Dykebar, and spoke to the head male nurse, as it then was, and said 'I'm thinking about doing my nurse training, which hospital do you think I should go to, to do that?' So he discussed the options about Ninewells, across at Dundee, which was then doing a triple qualification, four years; he suggested maybe I might think of going down to the Maudsley, in London, which had a world-wide reputation for psychotherapy or I may wish to think about staying in Scotland by going to probably the best psychiatric hospital in the world, the one which had an international reputation, which was the Crichton Royal Hospital.

**3m 42s.**

MS: And is that the words he used at that time?

IB: Very much, you know, in that the Crichton had a reputation, certainly across the UK, but also across Europe, and was well renowned for the quality of its training, the quality of psychiatrist that had worked there and especially the quality of psychology, the psychology department had always been a very strong one at the Crichton.

MS: Right.

IB: And it was the first hospital to actually pioneer training in mental health nursing. So the college, locally, had that reputation of being very much at the forefront of mental health care and mental health nursing.

**4m 21s.**

MS: And at this timeframe, period, was when then?

IB: This was 1976.

MS: '76, right.

IB: I actually went to a number of different places to be interviewed and was offered a place to train at the Crichton and took the decision that the Crichton probably was the best place to go to and that's how I finished up coming to Dumfries.

**4m 45s.**

MS: So, did you, were you interviewed for a place on the training school?

IB: I was interviewed by, I think it was a panel of three, the one who left a lasting impression was the male tutor who was called Noel Kirkman and Noel was very well-known, again through the Crichton, but also because he'd worked extensively abroad. He'd also been a missionary so he had a lot of life experience, interesting life experience, and I tangentially knew Noel before I came to Dumfries because the family was part of the Baptist Church in Paisley and Noel was part of the Baptist Church in Dumfries, so we actually knew each other slightly through the work of the Church. Having said that I'm no longer part of any recognised religious group or anything like that but at the time then, you know, many of us went to church, not something that you did routinely but it was much more accepted then than I think it is now.

**5m 46.**

MS: So, just to clarify, Ian, why psychiatry? Was that the influence of your mother who…?

IB: It's an interesting question with a not very rewarding answer. Because I'd worked as a nursing assistant at Dykebar, and Riccartsbar Hospitals for both holidays from school and when I was at university, when I had a chunk of time out of university I actually spent six months working as a Nursing Assistant, I knew that the people that I had worked with, who were student nurses, actually I could easily do what they were doing, in fact, do it better. And what I needed to do, in 1976, was to actually be covering my family's eyes from the period that I'd been at university and do something that I knew that I could actually achieve, so instead of going off to do a job that I didn't actually know about, I felt that I'd do my nurse training and that would give me that degree of recognition, would give me a qualification, and maybe give me a career. My ambitions about going to Crichton were to do my training, in 1976, I was going to go there, do my training and leave after three years and go and do something else. And life kind of comes along and things change and I think my ambition of going there and training and moving on just never quite got off the ground.

MS: Right.

IB: I stayed and worked in the Crichton, I worked in Dumfries and Galloway, worked across Dumfries and Galloway, virtually working in any job that would accept me as a manager, to give me the opportunity to do what other people do by moving around the country or moving around different countries. I worked from Dumfries to Stranraer to Newton Stewart to Castle Douglas, across into Annandale and Eskdale, back across to Dumfries, back across Lochmaben, back into Dumfries. I've visited every Community Hospital, every Health Centre, every GP premise, I can still walk down the streets of Langholm and somebody will stop me and say 'You're Ian Boddy, aren't you? I remember you, you're the man that used to talk about setting standards' [*laughter*].

**7m 55s.**

MS: Ok, let's go back to your training then, Ian. You said, what was it struck you about your training, then? What are some of the memories you have of that?

IB: I think what struck me about it was, you know, having come from the [?] of the university training, how rigid the training was within the South West of Scotland College of Nursing and Midwifery and Health Visiting. The classrooms were very arranged, the Director of Nurse Education was Daisy Fullerton, who was a bit of a tyrant, and I can remember being told off by Daisy for wearing a pair of white clogs to college because men shouldn't wear white clogs and they made too much noise, Mr Boddy, and you should now go home and get changed and come back wearing some more sensible footwear, please.

MS: So, did you…

IB: I duly obliged [*laughter*].

**8m 51s.**

MS: So did you have to wear a kinna prescribed dress when you were in college and on the ward?

IB: They were clear that we should appear smart but not wearing anything too formal. I did think that we would be wearing uniform in college itself but, no, we didn't but I think there was an expectation that if we went along looking too scruffy we would be told by somebody to go away and get changed and improve our appearance. It was quite formal, you know, I think there was an expectation that you would be there for lectures, you would be there for classes, you would be there at tutorials. Again, from that higher education at university, you know, there wasn't that same expectation, you would do it because you volunteered to do it. Doing the nurse training that I was going through it was very traditional and I think that's what actually struck me very much from the early stages, is how traditional both the training was and also how traditional mental health nursing was in Dumfries and Galloway.

**9.49s.**

MS: What do you mean by 'traditional'?

IB: I'd come from university where the subject which I'd enjoyed most was Sociology, and one of the key tenets of that was a book by a chap called Erving Goffman, <u>Asylums,</u> and having read <u>Asylums</u> quite recently within that academic context, realised that the, what was provided at the Crichton was very much, you know, an asylum. It was a complete asylum, everything was delivered there. The families that lived there had worked there for many generations, families didn't think about going to work anywhere else apart from at the Crichton. You would live in a family in which somebody would be and somebody else would go off and work within the kitchens or catering or portering or something like that. But whole families would be related to each other and would live on the premises, live on the grounds of the Crichton, usually living in a Crichton House. I mean, it was very much that closed community, a closed community in which it entertained itself, families married within families, you went to the Crichton shop to do your shopping rather than go down town. You know, there was, it was a community which I very quickly saw was very similar to the concept of what Goffman had described as the total asylum, an enclosed, closed institution.

**11m 11s.**

MS: Ok, so, you came from Paisley as an outsider, in a way, so where did you live and how did you feel you were accepted?

IB: Moving to Dumfries then, I had no options but to actually move into the Nurses' Home. And the Nurses' Home was actually great fun, I think a lot of us had a great time being in the Nurses' Home, there are many happy memories that I have of people who are now very, very senior in the Health

Service, who'd probably say the same about me but we enjoyed ourselves. The Crichton Club wasn't that far away, so you could easily go for something to eat and a couple of drinks and then you would go down town. But you'd meet people there who you would know for the rest of your working career. And that's maybe one of the nice things about the concept of the total institution, is that, you know, you did find people who you would, you would effectively grew up with and continue to grow up with even into older age.

**12m 07s.**

MS: So you are kind of describing being easily accepted into that.

IB: It was an environment in which you knew that there were some families that were very dominant and you knew that there were some names that were very dominant and if you belonged to some of those families then you almost had entry into a lifetime career working at the Crichton.

MS: Right.

IB: Coming in, as an outsider, you were very much seen as being both an outsider to Dumfries but also an outsider to the Crichton. And looked at with a certain degree of kind of curiosity, you know, 'Where have you come from and why have you come here?' instead of going to what was seen as the local hospital to train'. I think when people heard me say 'Well, I came here because of the reputation of the Crichton' they just smiled happily and went 'Yes, of course, we are the best in the world'.

**12m 57s.**

MS: How did the, you've described how you see it as a concept of the asylum, how was that manifest in the nursing practice then, that you found, in comparison to where you had worked as a nursing assistant?

IB: I think I came expecting the nursing practice to be something different from what I had experienced working at Dykebar and Riccartsbar, which were very similar kind of asylums, and realised very early on that actually the Crichton was no different from Dykebar or Riccartsbar and I think that the idea that the Crichton was the best place to train, because it was the best psychiatric care in the UK, I don't think was actually that valid. What I saw was very institutional care, care which was very much rooted within the medical model, and care in which the nursing profession was quite distinct from the other professions, there wasn't a lot of multi-professional, multi-disciplinary working. I saw a psychiatric hospital in which the Psychiatrist ruled the roost and effectively, you know, you did what the psychiatrist told you to do.

MS: Right.

IB: And this wasn't the advanced model of mental health nursing that I thought I would be moving into.

**14m 15s.**

MS: So, give us an example of how you saw, where you saw the discrepancy of that.

IB: I think in the way that that, basically that the Psychiatrist would visit a ward, would see the patient and would then tell people what to do with the patient. And, as the nurse, if you disagreed with that, then you were held to question, held to account and would be sent off to be given a lecture by somebody, the Nursing Officer, the Senior Nursing Officer or the Director of Nursing.

MS: Right.

IB: And, you know, it was an area in which the Senior Management in the Health Service was dominated by the Psychiatrists. And I was beginning to see a world, through my studies, in which meant that mental health nursing was becoming much more of a distinct profession in its own right.

And I thought that's what I would be seeing, I thought that's what I would be trained as, and sadly that didn't really happen. But I think that also gave me a great appetite to actually see whether or not I could be part of fundamentally changing the way that we delivered care within mental health, within mental health nursing, and within the Crichton itself and within Dumfries and Galloway.

**15m 33s.**

MS: So, was the care, the nursing care, very much a kind of care and containment?

IB: It was, I think containment is probably a very good word for it, a lot of care was about keeping people in. I think it was very defensive care as well, that you didn't take risks with people so you kept people in hospital wards when they actually didn't need to be in hospital wards. The Crichton, in 1976, had, from memory, I think about 850 patients and a similar number of nurses scattered across every ward, across the Crichton Campus. All of them had patients in at that time. And I think many of those wards, there were a couple of wards which were locked, mainly because they were looking after people who were seen as being very challenging, very disturbed, many of the other wards weren't locked but they may as well have been locked because people weren't allowed to get out of them.

MS: Oh right.

IB: De facto, you know, the intention was there, you know, that 'you may want to leave, well you can if you want to but I'm not going to let you go.' So, you know, there was a lot of kind of, I think hypocrisy and a lot of, I think people didn't do it deliberately, but I think people didn't really think about the way that they were providing care and about how they were providing mental health nursing care. A lot of those custodial, the male nurse was given to wearing a white coat, I have my old white coats, if you became more senior you got a red stripe on your sleeve, if you became more senior than that you got two red stripes and when you became Charge Nurse, you got three red stripes. You had your keys on a chain, attached to your safety pin in your coat pocket, and people strutted around being very important while patients actually weren't being looked after very well. The concept of patients having their own clothing was something which was really not understood because we had large wardrobes of clothes that were there, as ward stock, so patients of course could have their own clothing but they would actually wear anybody's clothing.

MS: Did they?

IB: So, you know, it was a long way away from what I thought it would have been.

**17m 51s.**

MS: So, you said, I mean, that it was one of the top psychiatric hospitals in Europe, so what gave it that credence?

IB: It had been a very progressive hospital in the '60s and I think, you know, it was still living on the laurels of many of the great medics that have come through and I think the great medics that had been through the Crichton gave it its reputation.

MS: Mm.

IB: But also gave it its culture and I think that the culture was one in which the medics were very dominant because they were very senior, they were respected across Scotland, across the UK, and I think it created that culture that that's where people went to. You know, the culture in which, you know, had done some pioneering work, round about different therapeutic regimes, you know the bungalows just off the Crichton site were the place where people went for Insulin Therapy and the Crichton had pioneered Insulin Therapy until somebody came along and actually said 'Have you worked out the science behind this because there isn't any science. All that you're doing is inducing diabetes in people', some of whom suffered consequently as a result of that. 'But you're not actually

creating any change in anybody's psyche or way of thinking.' The Crichton had pioneered very invasive psycho-neurological techniques, Easterbrook Hall had its own operating theatre, it carried out all sorts of bizarre operations on people's brains, some of which were successful, the vast majority of which just caused brain damage.

**19m 34s.**

MS: But by the time that you had reached the Crichton in '76, was any of that still being carried out?

IB: It was, you know I think at the time then, ECT was very much the treatment which was being questioned in mainstream psychiatry. ECT had a lot of critics, people didn't understand why it worked and were beginning to say, you know, 'Why are we doing this?' Certainly in the hospitals that I'd worked at in Paisley had continued to do ECT but were beginning to question why they were doing it.

**20m 08s.**

At the Crichton I discovered that ECT was one of the most popular treatments that you could possibly get, you know, there'd be a queue of thirty odd people on a Tuesday and on a Friday, waiting to get ECT. I always had [?], a couple of occasions that psychiatrists would come in and would effectively punish some patients who had been 'bad', in their word, and prescribe a course of ECT. And if you questioned that, you were told that you couldn't question that, that the psychiatrist had the right to administer whatever treatment that they thought appropriate and there were some psychiatrists who revelled in having that degree of power and authority which I had thought the mental health professions had actually moved on from but it was still something which was traditional and popular and that followed through at the Crichton. It was also a very drug-regime orientated hospital. I think that we'd had some very progressive Psychologists and some very progressive Directors of Psychology, but they didn't use many psychological therapies. They did use a few on a kind of experimental basis but most of the therapy at the Crichton was about containment, keeping people in wards, treating them with things like ECT, also treating them extensively with drug therapy. So Phenothiazines were becoming popular so that the drug of choice was Largactil, Largactil always had many side effects attached to it because it was found as a bit of a dirty drug, so you then spend, if you like, dishing out doses of Largactil, Triflouperazine, Stelazine or something like that, other drugs that countered the side-effects that went along with that. So it was a strange world to find yourself in.

**21m 57s.**

MS: You described there about some of the Psychologists, how was the relationship between them and the Psychiatrists?

IB: There was always a huge great big gap between them, you know, I think that they disagreed professionally about how to actually conduct their business so there was no great meeting of minds between the Psychiatrists and Psychologists. I think the only time that they met in any kind of constructive fashion was the annual cricket match [*laughter*] and the Psychiatrists would play the Psychologists and occasionally one of the sides, if they were short of players, they would co-opt in other players. The Psychiatrists were famous for co-opting in training doctors who would have come from South-East Asian backgrounds, who were often very good cricketers, so they would kind of bring them in. The Psychologists, God bless them, would recruit people like myself or other mental health professionals, they were a bit more open in many ways, so they always turned up, that I actually saw them together was at the annual cricket match.

**23m 02s.**

MS: Tell me a little bit about the social life then, of patients and the staff.

IB: The social life was, I think, seen as being a good one, I mean we had a Social Therapy Organiser who had an assistant so, you know, he spent his time actually creating social activities and functions

for the patients, so the annual kind of landmark events were things like the Easter Dance, Christmas Dance, Christmas Concerts. Christmas was a time of great happiness for the staff at the Crichton because they would all have individual Christmas parties, the Social Therapist would come round first thing on Christmas morning, usually with the Medical Director, wishing everybody 'Merry Christmas'. Each ward would have its own bar set out, on a cocktail trolley, so the Social Therapist and the Medical Director, sometimes with the Director of Nursing, would all have a drink in each of the wards and went on their happy way and would be legless by the end of the day [*laughter*]. And I think drink was taken in great, great amounts, you know, I think there was a lot of drinking going on at the Crichton. There was a lot of drinking going on outside of hours but equally I think that people were drinking when they were at work.

MS: Oh right.

IB: And it was something that, it was accepted at lunchtime that you would go to the Crichton Club, have your pie and have a couple of pints and then go back to work.

MS: Did you?

IB: Aye, it was something that I think only changed as people began to realise that drinking at work was something that actually wasn't good. The thought of the Charge Nurse coming to work first thing in the morning blind drunk, not being able to stand up, being put to bed by the rest of the staff and then waking up at midday and having his lunch, is something that, you know, you think of now, you think 'surely that didn't happen?' and yes it did.

MS: But that was just accepted, was it?

IB: It was part of the culture of the Crichton.

**25m 07s.**

MS: What about, you've described these events among the staff, where did the patients fit in, or did they have separate events?

IB: These were events were for the patients but I think that these events actually became more, more about the staff than it was about the patients.

MS: Right.

IB: So it was the patients' Easter Dance, but the staff would dress up and they would dress up the patients for it and take the patients along. Whether or not the patients wanted to go was another question. You know, 'You will go to the Easter Dance, unless you're physically very ill or mentally very, very ill, this is where you're going to go'. So these were events that were put forward as being on behalf and for the benefit of the patients. I didn't really see an awful lot of patients benefit from that, I saw a lot of staff enjoying them, I think it was seen as being part of the culture of what we do and you don't question that. Or you didn't until smart-alec me come along and say 'Why are we doing it like that?'

MS: Mm.

IB: I can remember being told off by a Charge Nurse, I qualified in '79 and at that point took up a one man protest by not wearing my white coat and actually turning up in the second line admission ward in Grierson not wearing my white coat and the Charge Nurse tolerated this for two days and eventually took me aside and said 'Have you not got a white coat?', 'Yes, I have, they're in the changing room', 'Well, go away and put it on' because at that point we were beginning to work into the kind of [?] where mental health nursing should be a bit more relaxed, it shouldn't have the barrier of the white

coat between you and the patient. Does it benefit you actually presenting yourself as a person not as this kind of figure wearing a white coat, wearing some kind of protective uniform, or uniform of a custodian? So yes, it was good at making sure that things didn't change.

**27m 02s.**

MS: You must have found, did you find that when you went through your training, learning a bit more about the psychology and all of these kinna therapies, that you got a bit, how did you feel learning about that and maybe not seeing it being in practice?

IB: I think what it did for me was it actually gave me a degree of inspiration and courage to say 'There's something here that I'd like to change'. You know, I've never made any secret of my political beliefs and should be, it's basically about socialism and the need to change the way that we live to be a more egalitarian community. And I think I saw what was happening at the Crichton as something that actually had to change, it would change, and I had a great appetite to actually be part of that change process.

**27m 55s.**

MS: Right. So you qualified in '79, so where were you then, what was your next step?

IB: '79, I qualified and I had a six month spell of being orientated to the Crichton which is always interesting how we spent three years there being orientated anyway, which meant that they could move you round wards at their free will. And I was then given a choice, I was interviewed by the Nursing Officer for my job and then interviewed at the end of the six months and given a choice of where would I like to go and work and I elected to go and work with the Substance Misuse Unit, which at that point was just becoming a significant new development. Alcoholism had always been treated as why it was in mainstream mental illness. And the best way to treat alcoholism is that you put people on large doses of Chlorpromazine and Sodium Amytal, detox them, and then send them back out to the community, cured, which of course didn't cure anyone. And a pioneering Psychiatrist came along with a pioneering Psychologist, it was Ian Cameron and Ron McKechnie, who had a belief that actually you didn't have to look at life as much as black and white and that maybe you could think about something called 'controlled drinking' and maybe you could do things like psychological therapies with people, to talk to them about 'Why do you drink?' and 'Why do you drink in the way that you drink? Have you thought about talking with other people about how you do this?' So Ian Cameron and Ron McKechnie set up the first ever Substance Misuse Unit, not an Alcoholism Unit. I knew both Ian Cameron and Ron McKechnie from my nurse training when, I think it was the final year of my nurse training, Ron McKechnie and Ian advertised for people who'd be interested in joining a group looking at, exploring psycho-dynamics, which was right up my street. So I went along and became one of two groups working with the Psychiatrist and Psychologist, in a small group of other individuals, Jim McDonald, who was a Nurse Tutor at the time, came along and Jim was very traditional man but he saw that things could be better. Lachlan Frame, Eddie Dolan came along so it was a wee, you know, we already had a connection and I recognised the work that Ian and Ron were trying to do round about substance misuse so I elected to go there and worked with Ian and Ron for, I think, all six months. So eleven months of post-registration, I applied for a job as a Deputy, and I became a Deputy after less than a year's experience.

**30m 38s.**

MS: Gosh.

IB: Just happens. I went to work in Grierson West, which at the time was a lot second line admission ward. A second line admission basically was a title that they gave a ward that you didn't really know what to call people. It wasn't an admission ward, it wasn't a long-stay ward but it was a ward where people had fairly intractable mental health problems. So I worked there for a year, I worked with a

Charge Nurse called Frank Burkett and Frank was like minded with me, looking for changing things, looking for the way that the mental health nurse could actually take a bit more responsibility over what they were doing, till you then started to have group therapy with patients. And trying to talk through thing like rotating, was it triads, where we had patients talking with each other and with a member of staff and leading them into a psychological discussion about how they behaved and the way that they behaved. We saw some pretty tough Psychiatrists who didn't really like any of this stuff.

MS: Oh right.

IB: We had a couple of Psychiatrists who came down a bit strongly against any of this messing around with people with psychology. 'You know, this is something that we don't agree with and we suggest that you stop doing it.' So, yea, we continued to do that but realised that we were doing it in area in which there was a lot of appetite for it but there was also, equally, a degree of resistance to it and the resistance was from more senior staff.

**32m 12s.**

MS: And was the resistance confined just to the Psychiatrists or was it within nursing staff as well?

IB: Most of it was led by the Psychiatrists but much of it was, there was a back swell by mental health nurses themselves, who didn't see that this was the way that mental health nurses should behave. I think it took people coming from outside to come in and say 'Actually, that's not how you should be doing things nowadays'.

MS: Right.

**32m 38s.**

IB: And I think some of those nurses felt it very difficult to actually accept that this was a change for the better. There were some psychiatric nurses who were brought up at the Crichton and came from Crichton families who saw things, that things could change or part of the process. Equally, I think there's, when you look round, about the half of them were very resistant and wanted to keep things in a way that they always had been. You know, I think there's this, a famous Dumfries phrase, which is 'It's aye been' and we've all seen it whatever walk of life you go into. 'Aye, and it's aye been like this at the Crichton so why make it any different, young man?' and I was causing trouble.

**33m 19s.**

MS: So, you were kinna, would you describe you were kinna at the forefront where things started to kinna change in the Crichton?

IB: I think I was one of a number of people who were beginning to say 'We need to change, we need to do things differently.' This is a time in which people were starting to think about doing Care in the Community. Care in the Community was rooted into the Mental Health Act, back in 1959, but nobody seemed to have told the Crichton about that. And I think it was a time in which people were beginning to talk about things, about moving outside of the asylum, moving into the community, were beginning to talk about things like Community Psychiatric Nursing. At that time I think we actually had created two part-time CPN posts, who both were based in the Crichton, worked out of the Crichton. And where we were then, in terms of where we actually finished up with is, you know, a remarkable degree of change. But I think that I was fortunate to be there at a time when government policy was very much saying 'You need to change the way that you deliver mental health care' mental health care had been seen as being the Cinderella of the Health Service and I was listening to the radio where, yet again, people are talking about mental health being the Cinderella. And it's sad that forty years later mental health is yet to reach and be awarded the recognition of how important it is and how under-resourced it is.

**34m 55s.**

MS: So, during your time at the Crichton, because you retired…

IB: I retired five years ago.

MS: …five years ago, so that was in 2010. So, for thirty years from 1980, say, for that thirty years you must have saw a tremendous change?

IB: I think, you know, that, eventually I think the change that started to happen was that people like psychiatrists began to see the need for change and I think they began to see the need for recognising multi-disciplinary working and recognising mental health nursing.

[*Interview interrupted by telephone ringing*]

MS: This is restarted after interruption by a phone call. Sorry, Ian.

IB: What were we talking about Margaret? We were talking about change in…

MS: Change over the thirty years that you were at the Crichton.

IB: I think that that was the start of the change, it was also a start of change that the health Board were beginning to institute. It was a change in which management became something which was recognised as being management not just something that you had the hospital administrator. So my career continued to develop, I moved into, after a year working as a Deputy, became Charge Nurse so within two years of registering I was a Charge Nurse. Fell out disastrously with a Psychiatrist who had a chat with the Senior Nursing Officer and, lo and behold, I finished up on night duty for a couple of years, which was, I think, an eye-opener and I still have very happy memories of spending the evening hiding in the rhododendron bushes with a flashlight, watching out for the Crichton Flasher [*laughter*]. Again, I went to the School, to the Director of Nursing, and said 'Do you know that your nurses are doing this at night, they're not actually nursing? Your most senior night nurses, the Charge Nurses, are actually hiding in bushes and hiding in darkened wards, trying to catch somebody who they call the Crichton Flasher?' The Director didn't know anything about that, so we effectively said 'You know, nurses have to start behaving as nurses and not as custodians or as amateur policemen or whatever'. And I think they were starting to see a difference in the way that senior management actually tried to bring about change. They started to think about moving patients out of the Crichton. The patient numbers were beginning to diminish, mainly because patients were dying and weren't being replaced. So the Crichton's wards were effectively becoming empty, it was taking on, it had taken on a very kind of dominant role in the care of dementia and there's an ex-colleague of mine, a psychiatrist nurse called Debbie Wood, says that mental health only acquired dementia by accident, it's because there weren't enough space in general hospitals for dementia care. Psychiatric hospitals were beginning to empty at that time and people said 'Well where shall we put all these people with dementia? We've got these empty psychiatric units, we'll put them into there.'

**38m 01s.**

So there was an awful lot of dementia care going on and, again, you would question about where your dementia care fitted in, you know, did it fit in as being a psychiatric illness or did it require psychiatric care but in the community? And, as people began to see that the realities that dementia care should have been provided in care homes in the community, close to where people lived and their families, I think people began to see the need for change. So I think that, you know, people began to chew away at the edges of what the Crichton had been doing and probably the biggest one that came along was the Resettlement Programme, which the Health Board caught up with, the whole idea of Care in the Community which had been carried out across Scotland. They created a Resettlement Team which was led by the Social Worker, included Social Worker, but included other individuals who worked as workers within the Resettlement Team, some of whom where ex-psychiatric nurses, some of whom

were OTs, and they then started to look at actually going through that massive process of resettlement, of moving patients out of the Crichton, moving resources from the Crichton, and the resources actually meant real pounds and moving people into Care in the Community. And they would have to find people who weren't employed by the NHS, may have been commissioned by the NHS, but effectively they were being looked after outside of the Crichton, maybe supported by a CPN or two. And I think that process began to see the massive change of reducing the number of patients at the Crichton. At the same time the Crichton was emptying, people began to say 'Well, what shall we do with these wards?' I, being, effectively I'd been round every psychiatric hospital in Scotland, and I saw what some Health Boards did with those wards and they'd basically locked them and walked away from them. Big psychiatric units in Glasgow, Inverness, were basically allowed to rot, frequently were torched and burnt by people but not [?]. The Crichton had a lot of support from the local community, I think it took some kind of enlightened thinking from both the Health Board and local council to say 'We must do something with the Crichton grounds' so they created the Crichton Development Company which came along and said 'Oh, let's take some of these buildings that are now empty and let's do something exciting with them. Let's think about what Lady Crichton wanted from the Crichton, which was that it should have been a university. Let's make this into a university now.' And I think out of that came some very creative thinking about creating both a university for the West of Scotland and Glasgow University and the move to take the College from Heathhall and put that on the Crichton site was all part of a great big package saying 'Let's continue to use the Crichton, continue to value the Crichton, to value the buildings for what they are and actually move the whole concept on of what we do with the Crichton as it stands.'

**41m 11s.**

MS: So, at that point, the Crichton is emptying and then there is an idea about having a new build, now we've got a new build, Mid Park, which has replaced the Crichton, but going back to your earlier theme of the asylum and how difficult it was getting people to change, what happened when people moved to Mid Park and all of these kinna ideas?

IB: When I became the General Manager of Mental Health in 2000, and retired from that post in 2010, so I had a ten year stint, why I took over as General Manager was the rump of the wards that were left at the Crichton and the start of a large community service. The Community Service was basically a psychiatrist who worked out of the Crichton wards and supported Community Psychiatric Nurses who were working in these individual localities and there were two kind of brands of CPN, there were people who looked after adults who, anybody from eighteen to sixty-five, and the CPNs who looked after the elderly who was anybody over sixty-five. And these guys worked usually with a psychiatrist and often they worked closely with Social Work colleagues, so on that basis we knew that in the south, in England, a lot of work had been done in creating Community Mental Health Teams. So we started to talk about the future of the Crichton wards and to talk about the future of the community and what we realised that we had to do, under the direction of the Health Board, we that we needed to look at the whole model of care for mental health that's being delivered in Dumfries and Galloway. And we recognised that the community was being developed but wasn't fully developed and what we also recognised was that the quality of the wards, in-patient wards, where we were looking after people who were very acutely ill, actually wasn't very good and actually it wasn't fit for purpose. And we knew it wasn't fit for purpose because as the General Manager of the brand new Mental Health Service, I had the luxury of the Health and Safety Executive knock on my door very early in the morning to say 'We've just been to visit your acute wards and they aren't fit' and the next week the Mental Welfare Commission came along and said 'We've been alerted by the Health and Safety and by other people about the wards and just visited your wards and they're not fit for purpose'. Well, that displeased me, it certainly didn't make the Chief Executive at all happy, who then summoned me and the Director to come along and say 'What are we going to do?' So, after an awful lot of brainstorming and working in twilight rooms, we realised that what we had to do was that the wards that we had,

we tried every combination possible of recreating them, of putting on extensions or whatever, but it was actually beyond that.

**44m 11s.**

The wards had been built, the oldest wards, back in the 1830s, the latter wards back into the 1940s, and they'd done well for round about 150 years but they no longer were actually fit to do what they were designed to do. They were doing things that they had never been designed to do, I mean the Hospice building which looked after the acutely ill patients, had been designed as a private accommodation block for patients who would pay and could pay for their psychiatric care, so it was mainly large rooms which were actually weren't any good. It was a long, long corridor, to go from one end of the Hospice block to the other, you actually needed a bike. I can remember walking those corridors late at night and it was a very long, long walk. So the actual creation of something different is something that was definitely needed. One of the things that the Crichton lacked was an Intensive Psychiatric Care Unit. When people became so acutely ill that they needed to be observed on a one-to-one basis, or a two-to-one basis, the best way to do that is to take them to an IPCU where there is security and there is staff trained to look after people like that, that's both in psychotherapeutic techniques, but also nursing techniques. What the Crichton did was, when they had people who were very acutely disturbed, is that they administered continuous observations of two to one and when you walked in the Hospice corridor all that you saw were nurses sitting outside of individual rooms, sitting on a chair, watching the patient, and that's all that they did and sometimes you had two nurses watching a patient if they were very disturbed. That wasn't good for the patient and it wasn't good for the staff.

**45m 50s.**

MS: What was the purpose of that?

IB: The purpose of that was to make sure that they didn't abscond, they didn't get out of their ward or their room and they didn't cause either themselves some damage or somebody else some damage.

MS: But there was no intervention?

IB: By and large the intervention one which was, again, very custodial, you know, 'We will keep you in there' and the rooms were not very nice, none of them were en-suite, they were often clouded in fag smoke, because patients would smoke and you couldn't stop them, so the whole concept of a therapeutic regime and a therapeutic role for nurses hadn't yet been continued, and the nurses continued to be, in many cases, custodians and they were very frustrated by that.

**46m 33s.**

I spoke to a lot of newly qualified nurses who said 'This isn't what I trained to be' and sounded a bit like me back in 1976, you know, kind of 'I didn't ask to be trained to come along and do this'. So we had to think carefully about what we do and how we do it. I did the initial agreement to go to the Health Board, I then did the second initial agreement because they poo-pooed that one and eventually we got round to the outline business case, which was accepted by the Board and supported by the supported Chief Executive who recognised how vulnerable the patients with mental health problems were in Dumfries and Galloway and equally how vulnerable the Health Board was because at some point someone was going to be ill-treated or be damaged and the Health Board would become liable, because we'd skated in thin ice over many years and I think we'd been fortunate not to actually come a cropper. So, with a very supportive General Manager and a very supportive Chief Executive and the Health Board, we happily agreed to go forward with Mid Park. We went out and consulted on our model of care, so what we had to do was create that whole model of care to say that not only do we have a new Psychiatric Unit but we have the range of facilities and resources inn the community to support people at home, because at that point we were looking at, I think we had about a 120 beds

left at the Crichton, and we were looking at downsizing that model down to eighty-five, so we were looking at a reduction in the bed numbers, we were looking at the creation of an IPCU and the creation of community infrastructure that would support people at home in the community, so that way all those people who were so acutely ill, requiring in-patient care, would come in and would then be quickly and fast discharged back into the community. The IPCU was probably the bit that was most seriously needed, because it changed the way that we actually delivered care in acute wards. It also was very, very unsafe and it was very risky. It used to be a Friday afternoon's nightmare because you would fill up with patients during the week, you wouldn't have discharged and you would have somebody looking for an acute bed and we would phone round every IPC in Scotland looking for an IPCU bed. And on one occasion we actually took a patient from the Crichton all the way up to Glasgow and round to Lochgilphead, which was, you know, in any circumstances, just mad. It was bad for the patient, because the patient was in the most acute episode of intensive illness, the staff had to sit in the back of an ambulance with the poor patient, the patient was, you know, five hours away from their family. Yea, it was inhumane to all concerned. It didn't help the patient, didn't help the family, it didn't help the staff. So we made the case for an IPCU, we made the case for new wards which would be single room, en-suites, we made the case for a bit of imaginative thinking going into the new unit because we don't know what care is going to be like in twenty years' time. So David Hall, who was the Medical Director at the time, well still is the Medical Director, hit on the idea of creating swing beds, set in between the two acute wards, we had doors that could actually move to create a large ward or a smaller ward or a very large ward, so that there were ways that you could actually accommodate patients who we couldn't currently look after. We also used a bit of imagination round about the layout of the wards because we weren't trying to recreate what we'd already got, so we know that we've got certain diagnostic groups who aren't very good at fitting in, when you've got patients with anorexia, you want to nurse them in a separate environment. When you've got very young people you want to nurse them in a separate environment, so we created a couple of suites at the end of wards so that patients could be looked after on their own in their own accommodation. The community, we looked at this gaggle of CPNs across Dumfries and Galloway and we created Community Mental Health Teams and the Community Mental Health Teams were fully integrated, were joined up, they were managed by myself as the Joint General Manager, so included the staff working from both health and social work. It included pulling of the budgets, so we had individual budgets for Care in the Community and you had nurses and social workers actually doing commissioned care. We created brand new Rehab Team in the community and we created probably the most important bit of keeping people in the community, we created the Crisis Assessment and Treatment Service, which was an acute service which would go out at the request of the Out of Hours Service and managed people in intense acute breakdown, in the community, and if they couldn't look after people then the decision would be taken to bring them into hospital. But CATS was probably, did the most important part of developing the community infrastructure. We were also changing in legislation so we were beginning to look at things like Forensic Forums and recognising that there are people with mental health problems who may also be breaking the law in some respect, not breaking the law because they're mentally ill, but breaking the law when they want to, so we created a Forensic Forum and a Forensic Specialist Team and Eating Disorders Service. We had a Day Hospital in the community, which supported people who had eating disorders, and what we could then say, to both the Health Board, is that we've got a whole package here which justifies that we're approaching Mid Park as the new model of care and it also explained to the community what we're doing on their behalf and how we are trying, as a service, to deliver Care in the Community, not just through Mid Park which is always going to be the centralised facility but by individuals who are professionals who are trained, working in a multi-disciplinary and multi-agency, multi-professional function.

MS: What strikes me, Ian, is you started off at a time in '76 and you described the Crichton as an asylum with its institutionalism, here you are thirty-four years later describing a totally different service there, and I think it's at that point that I'm going to say thank you so much for sharing your thoughts on that.

IB: Thank you, Margaret.