Interviewee: Ian McIntyre (IM)	Interviewer: Margaret Smith (MS)
Date of Interview: 4 March 2015	Ref: DG38-1-1-1-T

MS: Ian has agreed that he will share his memories of the time of his working at the Crichton Royal Hospital. So, Ian?

IM: Aye, hello, I'm Ian McIntyre, I'm fifty-five years old, my date of birth is 15/04/59. I was born and bred in Kirkudbright and embarked on a Mental Health Nurse training, in January 1977, at the Crichton. To be perfectly frank the reasons behind me choosing nursing were quite unclear to me then and probably they are no more clear now than they were then. It was a notion that ah had and ah suspect that if ah had approached an interview in this day and age wi that kind of vague idea of what ah wanted to do I'm sure ah'd be shown the door. But anyway, I managed to bluff my way in. It was a bit of a shock because, first of all, it was the first time ah'd moved away from home and lived away from home and, although it was only thirty miles up the road, it still was a pretty strange experience. And a moved into Crichton Hall an ah was in a corridor called Cairnsmore, ah think it's still called Cairnsmore, which is in the, it's in the side of Crichton Hall, above Cluden, and I was in there for a number of weeks because, at that time, there were many, many people lived in so there was pressure on bedrooms and eventually ah moved over to High East which is part of the original hospital, and into a corridor, of course in these days there, it was all single sex. It was quite an experience, there were people there who weren't nurses, had lived-in for years, it was their home. For example there was an old boy who was a porter at the Infirmary, had been the 'pig man' and they closed the piggery, he went to the Infirmary to work as a porter, he'd lived there for years and years. Another man was a gardener and he lived, he lived-in for years before he moved to Thornhill to be the gardener-handyman.

MS: Gosh.

IM: So, it was their homes and likewise in the domestic staff, many of them had been there since probably they left school. And there was cooks and so on in the corridor, there'd be some lab staff. The medical staff, of course, had superior accommodation.

MS: Oh, did they [*laughs*]?

IM: But it was ok and it was just cheap as chips and the company was good. As it transpired, I was the only male in my class, it was a very small class for that time, I think. It was the January intake which was always smaller than the September one, so there was me and fifteen young ladies [*laughter*]. Most of them, we were all round about the same age, there was no mature students, there was nobody in that had embarked on a second career or anything, which is quite different now, you get people who've done degrees, first degrees elsewhere.

3m 22s.

So I was spoiled a wee bit and I was, I guess I was looked after. Some of them had done their pre-nursing course and they had a slight edge on others that were in the class. We were quite a cohesive group, as far as ah can remember. Amongst the tutors, at that time, was the late Davie Shankland, Noel Kirkman, Andy Lovelow was training as a tutor at that time. Audrey Kelly, who later became the Director of Nurse Education, was one of the senior tutors and, of course, in these days as well, there were clinical teachers. There was Jim McDonald and Sarah McCombie and a real gentleman, called Alec Cruikshank, who is sadly long gone, who was an Invernessian and was as canny as get out, but he was a right sound character and a very interesting man. And these were the people that guided ye through your training and they were, although having said that, I don't know if we were necessarily all that well prepared for the wards. We did get taken, every Monday we got taken, for an hour intae

a ward, to assist with something or other. But ah remember appearing in ma very first ward which was Brown House, which was home for fairly elderly men who had been in hospital for a long, long time with chronic mental health problems. Some of them had learning disabilities, there were some were blind, I think there was three or four were actually blind, if ah remember rightly, so it was quite a mixed bunch, some would have acquired brain injury. But ah remember arriving the first morning and I asked the Staff Nurse what to do and she said 'Shave Mr X.' so ah went and shaved Mr X and said 'What do ah do now?' and she said 'Shave the other twenty-three' and ah thought 'Good grief, these men can't shave themselves, but in fact, what ah didn't really understand was that they were institutionalised, and they had never been really encouraged or allowed to shave themselves. And what ah found was that we did everything, you know, we bathed them and we changed their clothes and all that kind of thing. We made their beds, which ah found very odd, ah remember one blind man, actually, who insisted on making his own bed but we made everyone else's beds and we put clean clothes out and put their soiled clothes away to the laundry. We made tea and coffee and you wouldn't want to drink the tea and coffee that was made because it all went in a gallon-sized pot, sugar and milk, the lot, and then it was poured into plastic tumblers, which ah never really understood, to be perfectly honest, and it was handed out and yet the other, the other kinna, the nurses they had control of absolutely everything. A lot of the old men smoked and most of them didn't have their own cigarettes so the fags were dished out at certain times of the day and these old boys would sit and puff away and some smoked pipes, they looked after their own tobacco, but it was very, very institutionalised and there were a number, there were a few single rooms, not many, but it was a Nightingale ward, it was a big dormitory and there was no evidence of any personal belongings, there was an occasional photograph but there was nothing to say that they had a life before. And they were men who were the same age as ma grandfather and ah couldn't really understand their predicament.

6m 58s.

MS: What about their personal clothes? Where did they stay?

IM: Right, their personal clothes were, there were huge cupboards in the corridor as you went into the kinna day area. So they were kept in there, so they had pigeon holes I suppose and hanging space. They had personal, they had individual clothes that, you know, were marked with their names.

MS: Mm.

IM: I understand that, not long before I started, that there was no personal clothing, it was communal. And if fact I went to work, in later years, in Dundee and ah found that that was still the case there. When ah did ma learning disability stint at Lesmahagow, at Birkwood, it was horrific in the sense that it was all communal clothing, there was no buttons or zips, it was all elastic waists and horrible nylon shirts. So it was a real eye-opener, a real eye-opener.

MS: That's interesting, Ian, because what you're really talking about is the physical care. What about their mental health?

IM: Well, ah think that's, in my career, has been the biggest shift is from just, from care to treatment. So what treatment did they get? Well, we kept them fed, we kept them watered, we kept them safe. If they had a cough or a sneeze we got a doctor, they got medicines, as far as I would describe, from my experience, ah wouldn't say that there was any specialist care, that I would describe, being delivered at that time so…that was in the early seventies. Some of the men went out to work, they went out to industrial therapy, but it was work which they got some payment for. The other men, some went to occupational therapy. On one of the other wards some of the men didn't go anywhere, they were in the ward all day or they would get going for a walk in the afternoon, go to the canteen. But in terms of either activities or therapeutic activities, I don't remember very much happening at all. The occupational therapy was soul destroying.

9m 17s.

MS: Was it?

IM: There was a, a percussion band was one of the things that they had and it was called 'The Merrick [?] Percussion Band' and it was Harry, the late Harry Wood, who was the hospital musical therapist in inverted commas, he was the hospital musician, he wasn't really a therapist, Harry would play the piano and all these cymbals and drums would get beaten tae various degrees and there was other fairly, I would describe it as, fairly soul-destroying tasks, would take place. So nothing bright and cheery and very exciting, very few visitors, I can only remember one and at that time we were placed for eight weeks in the wards and at that time, I only remember one patient having a visitor. So most of these men were very isolated. I remember one man came along, who had been in hospital, he had congenital syphilis, he had been in hospital since he was about seventeen and by this time he would be probably in his early seventies and ah remember him, the man in the ward next door was dying, and he came in and asked me if he was dead yet and I said 'No' and he said 'That's a pity because when he's gone ah'll have been here the longest' [*laughter*] so there was that kinna competitive element. This old boy also, ah remember, used to deliver the newspapers round the hospital and he walked with two sticks and he had this kinna box contraption tied round his neck wi the newspapers and ah remember ah came across him one day, he was in tears, the wind had caught his box and tipped it upside down and the papers were everywhere and he said that he wouldn't get paid because the papers wouldn't be delivered, so ah jist huckled them together as best ah could and said 'There ye go, just deliver them' [*laughter*]. There was other strange, really strange things went on, just while ah remember. There was a report was done at the end of every day so any significant incidents or anything that happened on the ward was noted in this book along with the staff that were on duty, the water temperature was recorded, ah'll tell ye about that in a minute, and any visitors that had been and any patients that had been out working. But ah remember a patient came to collect the report, and in later days when ah was a Staff Nurse, ah remember sealing the envelope, and ah got a phone call from a long dead Nursing Officer who said 'Why did you seal the envelop?' and ah said because I handed it to a patient and he said 'But he wouldn't read it' and I said 'Well, how do you know?' [*Laughter*]. Anyway, the temperature of the water was a result of an incident way before my time, 1969, when patients scalded to death so as a kind of measure, they regulated the water temperature and every day it was recorded. Of course most folk didn't record it, they didn't test it, they just recorded it. But that was one of the kinna strange rules of the institution.

12m 24s.

MS: What about mediation for the patients at that time?

IM: Right, at that time we were still really in the fairly early days of medication. There was a small group of anti-psychotics, small group of anti-depressants. Anti-psychotics, were the ones that were developed in the '50s, [?] Largactil Chlorpromazine was one that was used, it was trialled at Crichton with Dr George Stirling, in 1955. So mainly we had Chlorpromazine, Fluphenazine, Triflouperazine and Thioridazine. Thioridazine was the kinna cleanest of them all; Fluphanazine and Triflouperazine were very dirty, people would develop horrible side effects, they'd have Tardive Dykenisia and they'd be, you know, Facial Dystonia, horrible, horrible side effects, Akathisia being the worst and if ye've never experienced Akathisia then I guess it's difficult, it's been described as 'a feeling of inner restlessness' that you can't do anything about, your legs are restless, your body feels restless. So people were living like that for years, you know, and of course the number of these patients had had pre-frontal leucotomies in the '40s and '50s, so that clouded the picture with a lot of them because their behaviors had changed as a result of the leucotomies rather than of medications. And things like incontinence was common but that was because of leucotomies rather than the mental illness. The anti-depressants were still pretty crude, it was still things like Amitriptyline, Imipramine and one I've forgotten, it'll come back to me, Chloroprene, which was still being used latterly. ECT was very much still in vogue, the ECT suite was, the ECT was carried out in three centres in the hospital, Crichton Hall and Cree North. Grierson West, upstairs, there was a suite and in Hospice. The numbers in Crichton

Hall and the Hospice were fairly low; the numbers in Grierson were very high, both from Grierson East and West, which was acute wards and from the long-stay wards, because the patients were still receiving maintenance ECT.

MS: Maintenance ECT?

IM: Yes, so they would get one a fortnight or two a month or something like that. There is still, I believe, some evidence that shows in depression that that works. But these were generally behaviourally disturbed patients.

MS: So they weren't, it wasn't really being done for depression?

IM: No, it was really more about their challenging behaviour.

MS: And who made the decision? How was the decision made?

15m 29s.

IM: Well, everything was very much consultant led.

MS: Was it?

IM: Absolutely, the consultant boys, I mean the consultant's word was final. I think I need the caveat, I suppose I need to throw in here, is that if even in the short, my short career, if you compare the history of the Crichton, 150 plus years, my short career of thirty-seven or thirty-eight years, the biggest changes came in my career because diagnostic criteria got much more sophisticated and patients who were being treated for schizophrenia when I started probably had personality disorders. So the behavioural disturbance probably wasn't down to psychosis but personality disorder which would be managed very differently now.

MS: Yes.

IM: I fact, I think some of the people who had pre-frontal leucotomies probably had personality disorders but the diagnostic tools were very crude, so that is one of the things that has constantly changed and improved, their diagnostic criteria. And treatment options, of course, are much better now, there were a number and interestingly there were more women who presented with serious challenging behaviours, assaultative behaviours, self-harm, swallowing safety pins, buttons, razor blades, that type of thing and retrospectively they were probably women who had been abused.

MS: Right.

IM: But were now in an institution where they were almost given license to do what they wanted, they could go mad because they were in a psychiatric hospital so there's that, almost a license to act out and not take responsibility. So that's been the huge shift in how we manage people. But going back to ECT, when I was a student nurse, what would happen would be you'd get a callout from Grierson West, or the other wards to ask if they could send staff tae help and about twenty-eight or thirty patients would perhaps appear up in the waiting room in their night clothes. They would go into the treatment room, so there was a treatment table and a recovery area and one anesthetist, and a psychiatrist applying the shocks. So the anesthetist was essentially looking after two patients at one time which, I don't remember any horrific incidents and ah don't know why. I don't know it never happened because it was all 'fly by the seat of your pants' stuff. The other thing was that when the patients were taken through after treatment into the recovery bay they were put onto beds so they were kinna rolled off the high trolley on to a low bed, so there was many backs put out doing that, and there weren't enough recovery beds so as soon as somebody's eyes were open they were hauled out the bed and taken downstairs and given a cup of tea and a bacon roll.

18m 21s

These were the good old days, these are the times that folk see with rose-tinted glasses and I don't at all. You know, there's, on the appreciation side, there's a lot of, ah think there's a lot of, ah think there are some fond memories, but ah think the reality was they were good times for the staff but probably not for the patients. There was, the other major changes that happened in my career was that we had three different Mental Health Acts and each one improved the life of patients, both in terms of where they were cared for and how they were cared for so the 1960 Act was in place when ah started and it had actually reduced the number of patients who were, what was called 'sectioned', who were detained in hospital, so there were many more who were informal and had the right to leave. Then the '84 Act, we had much more of a community focus with Community Orders and that improved things and that was really, you know, that was pivotal to us closing many, many beds and people moving out, quite rightly. And then, the most recent Act, 2001, which empowers patients more than ever and takes away…detained patients were, they were seen by the Sherriff, the medical recommendation and they had to go down to Chambers and be seen by the Sherriff and the Sherriff would grant you order. Now that's now been taken away, they're seen by an independent psychiatrist, by a legal person and by a lay person so that's, the focus is all changed, for the better, and people have got, obviously, right of appeal and so on.

MS: How did that go down, with all of this changes through the Mental Health Act, among the staff team? Among the psychiatrists, the nursing staff and that?

IM: I think, I was working in Dundee when the '84 Act came in and I was working at Ninewells in the acute, I was a Charge Nurse in an acute ward there, and that was, it was part of the teaching hospital, so it was a very progressive unit, so it was a bit of a cinch to actually bring in the Act and to change practice, couldn't really say what it would have been like here. Ah know that in the lead up to, probably from the early '90s, in the lead up to us reducing beds and eventually closing Crichton, there were some people had some old ideas about what could and couldn't be done. Ah think, it was supported by legislation so that they changes were enshrined in law which made it easier and there was a, you know, a good number of staff in the early '90s retired, they left, they got the opportunity to go, there was money at that time to allow them to go and that was good because it allowed the younger staff to kind of take the reins and by this time the control was very much coming out the consultant's psychiatrists' hands and decisions were being taken as a team which was much safer.

21m 32s.

It's much easier to manage risk in a team than it is by the individual taking risk. So that was one of the other big changes. But you know, if you look back, probably just when I when I arrived at the Crichton but certainly in previous years, the old Physician Superintendent was the boss, and he took decisions about everything, you know, including nursing staff and domestic staff , they had an absolute overview, they completely ran the place with Matron. And Dr Tait was still around, he was probably the last of the old-fashioned Physician Superintendent and although George Stirling was fairly autocratic, he was progressive, so George was pretty good and he had rehabilitation as his main interest. So patients being discharged into the community didn't happen in the late '80s and early '90s, it wasn't Mrs Thatcher, it started way back in the late '50s and of course with the 1960 Act and the change in medication, the improved medications that were available, people were expected to be discharged home rather than kept in hospital. So there was a shift over a long time and it became much more rapid, I think, in the late '80s and early '90s through improved treatments, drug treatment and therapies, psychological treatments, CBT and so on, psychotherapies, and just a whole change in the balance of the way we managed things and a change from hospitals, mental health hospitals over the years had become dumping grounds for a lot of social misfits, for the worried well, you know, for people…drug and alcohol problems, so psychiatry got its act together and said 'We deal with severe and enduring mental illness, we deal with mental disorder, we don't deal with the worried well.' So there were other avenues were explored for people with neurosis and anxiety disorders through primary care, so the whole focus shifted from treating everyone in hospital to actually treating almost

everyone out of hospital and only the most ill people in hospital and they would generally be people with psychosis or dementia with a challenging behaviour.

MS: So, therefore, I mean, at the first you actually described your nursing experience as actually doing the care…

IM: Yes.

MS: …part, with very minimal, if at all, so nursing practice must have changed.

24m 12s.

IM: Nursing practice changed greatly over the years because one of the problems in mental health, in my early days, was that there was, you know, you qualified RMN but thereafter, unlike in General, where you could go and do orthopedics or critical care or coronary care or go into midwifery or, there were no other pathways of training and any other, any additional training tended to be short, you know, weeks, maybe a couple of months but there was no other training that was recognized perhaps by the, who would it be then, the GNC. There was a couple of male nurses went and did a course called Advanced Psychiatry, in Edinburgh, but ah'm really not quite sure what that brought back because I remember them coming back and I don't remember things changing very much. [*Laughter*]. Your bigger issue about the Crichton was that there was always a problem with big groups of families and kind of lack of fresh blood in the place so there were generations of families had worked there…

MS: Oh, you mean as employees?

IM: Sorry, as employees, and that carried on and that often was difficult to break down because they were tight and to try and bring in change was often difficult and some of these people were in senior positions. So it was difficult to implement change, you were sometimes, well to quote a Nursing Officer of the time who said to me 'You're a cheeky young bastard' when I suggested that we were maybe not doing things the right way. So that was the kind of culture, I suppose, was and a lot of the Charge Nurses and senior Sisters were, they were getting on in years, and they had grown up and worked and had a career in this kind of institutional model, so the idea of actually trying to change practice to them, was 'Oh we've tried this before, it didn't work' so, you know, a number of them all retired round about the same time and then there was the kind of younger, eager, hungrier staff round who really wanted to embrace change and make change.

MS: Like yourself?

IM: Well, I'm too modest to say [*laughter*].

MS: So, once you qualified, Ian, did you then move to Dundee for a…?

IM: No, I went to the…I was qualified for about eighteen months and then I went, I was seconded to do my general nurse training at the Infirmary.

MS: Oh, and how did you find that?

26m 47s.

IM: I quite enjoyed most of it, it's interesting because I think…the wards were very different, which I found interesting, for example, some wards were very kind of patient orientated so you got a group of patients to look after with various problems. Other wards were task orientated so you would get half a dozen baths and half a dozen shaves to do and somebody else would attend to their other care needs, so it was a bit of an eye-opener, really, in that sense.

MS: Yes, yes.

IM: That would be the end of '81 and all of '82, but the Infirmary, then, was beginning to change as well, because there were younger staff, senior staff were imposed, you know, I worked in Ward 14 with, she was then Julia Richardson, Julia Adam, Julia was a breath of fresh air you know, she just had such a wonderful personality and she was open to discussion about things, where maybe in other wards that wouldn't happen, so it was really quite varied. Didn't do any A&E which I probably would have quite liked to have done, the choices were A&E or Theatre, you couldn't get both at that time. It was enjoyable and the group that I joined they were, I think there was seven of us went in as Post-Reg.

MS: Right.

IM: And we joined a fairly big class, in fact that class was the last one of the, oh gosh what year would it be? '74 or '75 so it was, I think that was the last one before…

MS: Before it moved up to Bell's College?

IM: No, the syllabus changed.

MS: Yes.

IM: And then it changed again to Project 2000, so that was kinna the last group. So, I had some interesting Post-Reg colleagues, they were mainly from Sick Kids and there was one, no, one or two RMNs, I just can't remember. The Sick Kids nurses, ah remember being so impressed with, they had trained at Yorkhill and they were as sharp as knives, they were absolutely on the ball and they were so impressive, you know, and they absolutely, they sailed through the program, it was no big issues. I still keep in touch with one of the girls from there. So that was, so then ah came back to Crichton and ah was feeling a bit restless and ah suppose ah must have been a kinna 'cheeky young bastard' because ah got a Charge Nurse's post in Dundee and ah think ah got, ah think ah just flew by the seat of ma pants when ah think back.

29m 48s.

So there ah was, a charge…initially went to what you called a psycho-geriatric ward, then, and Dundee, although it was part of the Royal Group of Hospitals, never quite had the same kind of prestige as the Crichton although there were pockets of excellence in Dundee. It had a Metabolic Research Unit, for example, and they had a CBT department which was run by Prof Phil Barker and the ward I eventually went on tae, tae be Charge Nurse in, was run by Prof George Fenton, who was a pretty eminent man in his time, so that there were pockets of real expertise and excellence but there were some horrendous places as well and the ward I went to was one of the horrendous places. It's interesting because management was very weak there, Unions were very strong, and it was a completely different culture for me. A lot of people who were there had worked in factories, they'd worked at NCR, they'd worked at Timex, they'd worked in the mills, so they had a completely different attitude. So I was Charge Nurse there on the ward for about a year and then there was the opportunity to go across to Ninewells to a small acute unit and it was just wonderful there. We'd a really progressive team and at that time staff were being trained in CBT and we worked with Phil Barker, there was a psychologist attached to the unit, Senior Registrars, I mean luxuries that I hadn't seen for a long time so it was really, really good experience and ah learned a lot but yet when ah think back now, good grief, I was only in my mid to late twenties in a unit like that, you know. I used to think that sometimes when I was at work.

MS: So you then came back to the Crichton?

IM: Well, ah came back to be a CPN, to be a Community Psychiatric Nurse, at Newton Stewart, in the Machars region, and that was when the Community Teams were really beginning to spread. No, that's no true, the Community Nursing Service was beginning to spread, they weren't teams, they were individual CPNs, based usually in Health Centres, so in terms of bodies there were many more. There

used to be about four for the whole region, there might have been twelve when ah came back, so that was at a time of change and through that I got sent to Queen Margaret University and ah did the Diploma in Community Mental Health Care and a Diploma in Nursing, yea, a Diploma in Nursing, so that was quite useful and that was helpful. On the negative side the post was very isolated, my nearest colleagues were in …another colleague in Stranraer and the next colleague, then it was Dumfries after that. There were no teams as such whereas now it's Community Services are based in teams, so you've got a range of professionals and as ah said to you earlier, managing risk is much easier when it's like that. So, I went out there full of enthusiasm and got burnt out really quite quickly and came back after about three or three and a half years to Acute…to Ettrick Ward, which was part of old Hospice, and I inherited a ward there with a fairly good reputation and a fairly well motivated and younger bunch of staff. So I spent a long time there, I actually can't remember how long I was there, maybe ten years. I came out at one point and ah did the initial Service Review for the Mental Health Service, well it was actually the hospital based services and almost right away I recognized that there's no point in redesigning the hospital, you've got to redesign the whole service. So that was really where Mid Park was spawned from, that work. But also the change to the Mental Health Teams, the changes to the way we do things and, I'm talking as though I'm still working, change the way we did things. And I got the opportunity, then, to go places and see what was happening elsewhere and ah got very, very excited by what I saw, when I saw Home Treatment Teams in Newcastle who, they closed beds and people were looked after at home and that really is what the new Act was about, new Mental Health Act was about looking after people either at home or closer to home and the specialist services they need so that kind of fitted with the model and the outreach components.

MS: So, did you then, were you then responsible then for Mid Park?

IM: Yes, I was…when we got Mid Park I was the Project Sponsor, so David Hall, who was the lead clinician, no he wasn't, he was the Clinical Director, was the Project Donor and I was the Project Sponsor which meant that I had to, was kind of second-in-command although I had day to day hands-on running of the project and ah had authority to spend up to a hundred thousand pounds without consulting the Board, which I never, ever did, but ah had that authority [*laughter*]. So, yes, Mid Park was my kind of parting shot. Other things, just going back, Margaret, that…significant things that I remember: when I was a Staff Nurse there were ten Charge Nurses on night duty, there were ten Charge Nurses, three Nursing Officers and a Senior Nursing Officer. This was for about maybe, I don't know, maybe 800 beds. All the wards had a Registered Nurse in them at night, it was complete overkill, they were, the staff weren't allowed to make decisions. For example, if someone became ill during the night they'd to phone the Charge Nurse to get authority to call out the doctor, so basic clinical skills were being completely eroded by this overkill of all these people who did who knows what.

MS: Why was that? Why did they, where had that…?

IM: Well, this was ah think an old institutional kind of model. I think when the Salmon Report came in this is when they started to overload night duty. So we had all these senior staff on nights, more on a Saturday night because they signed the pay…most people were paid weekly then, they signed the pay-slips, so all these people were there signing pay-slips and nobody really knew what they did.

36m 39s.

And then Margaret Stewart and I in the mid-nineties were given the task of dismantling the whole night admin, as they were called, they weren't even management, they were described as admin. So we dismantled the whole lot and put a Charge Nurse on call in place. Margaret and I ran it between us at night for a few months until the staff got used to this idea, that there'd be no one around, because what we found was that there wasn't an awful lot happened at night and we did a kind of 'what if?' scenario, training staff. What if, you know, and staff actually realized that they did know what to do so it was training and empowerment really and we put an on call system in place, which is

still in place to this day, so we dismantled all that top heavy management, although it had eroded down, certainly, it wasn't as heavy as that by this time. So we got rid of all that tier of management and reinvested the money in daytime when people were awake and when we could do things with our patients. So that was, that predates the service review but that was, I suppose, part of the kind of creeping developments that we took part in. The retraction was another big piece of work but ah was on the periphery of that, Margaret Stewart and Moira Cosser did most of that.

MS: What was that?

IM: That was when we closed down the wards.

MS: Right.

IM: Places had to be found for patients, places had to be found for staff, so that was a big piece of work. It all went well, there were predictions of disaster but disasters never happened, I think which underlined the fact that a lot of these people were being hospitalized, they were being medicalized when they didn't need to be and they were moving into tenancies. And I said to you earlier, you know, that…people still say to me 'It's terrible what they did to the Crichton' an ah say 'Well, would you like to sleep in a dormitory wi' twenty-odd people you don't know and have no belongings? You know, not even have access to a kettle or cup of tea when you want it? Or food when you want it? You know, be told to go to bed at half-past nine or ten o'clock, told to get up at half-past six in the morning, just to be bored, not to have a choice with food? Not to have any choices? Not to have any friends, any visitors?'

39m 06s.

People actually ask what life was like for long-stay patients and the more able ones were the ones that shouldn't have been there, you know. I remember there was one lad who was in, they had a number of what they called 'hostel wards' and they were developed in response to the 1960 Act, so these had previously been staff accommodations, Nurses' Home and a so on, Heston and McCowan, and ah remember one guy who worked for the Council, he worked on the dust lorry, and he went out every day to work, why was he here? But there was another man ah remember worked at Lady Park, at the egg factory, he worked there for years and the family, the Kerrs, were very supportive of him and that, you know, they're not isolated, there was men who worked in the gardens and the farm, they worked on the vans, some worked with the tradesmen. And then there was Solway Industrial Unit which folk say 'It's terrible it's closed' but there were people there doing very repetitive tasks that were, they were occupation but they would neither be satisfying, nor educational, nor progressive in any way, you know, making up boxes for Carnation.

MS: There was nothing therapeutic about them.

IM: Nothing therapeutic about it. But, you know, at the same time it was horses for courses, when it opened it was held up as a kind of pioneering unit but there is, I think there's a, there is a time limit on everything in mental health and there are times when you've got to move on, you can't cling on to the past.

MS: So, Ian, thank you, I think we will draw that to a close because you have given us such an insight into the Crichton. Is there any final comment you would like to make?

IM: Yes, I hope I don't sound like a bitter old man, but I just think that mental health and mental health nursing has progressed in leaps and bounds since I first came into the profession and I'm proud to have been part of the change. All I ever wanted to do in my career was to make things better and ah think ah probably did that. I had a modestly successful career, the swan-song was Mid Park Hospital which I used to show off with pride because it is, I think, the best mental health facility in the UK, certainly in Scotland, but I'm sure in the UK. It's very innovative but it's only for people who really need to be in hospital, most folk get cared for at home.

MS: Well, thank you, Ian, thank you.