**Work, rest and play: professional and social progress of nurses at a British mental hospital in the early 20th century**

**Introduction**

In the past, psychiatric nursing was confined to a segregated institutional system. In the twilight of the Victorian era therapeutic optimism had dissipated, and the role of asylums in Britain shifted from cure to confinement as individualist ideals were overridden by centralised policies of social control (Jones, 1993). Those considered deviant were to be kept apart from society, and while the notion of a ‘dumping ground’ is simplistic retrospect (Porter & Wright, 2003: 7), an increasing number of people incarcerated in asylums were casualties of social circumstance. Severe overcrowding necessitated a renewed spate of building, with a contemporaneous expansion of the workforce; the nursing staff of British asylums reached twenty thousand by the turn of the century(*Asylum News*, 15 January 1901).

Critical historiography has highlighted the neglect of nursing in the story of asylums and mental hospitals (Borsay & Dale, 2015). Until the mid-twentieth century, nurses wrote little about themselves and their work. Most of the documentary record of mental hospitals was written by medical officers, with no direct nursing contribution. Therefore, data sources such as patient casebooks are likely to ‘contain inherent class and professional prejudices’ (Shepherd, 2014: 41). Official reports by medical superintendents, such as Harold Kidd at Graylingwell, extolled the virtues of their institutions, with some corrective provided by the national inspectorate (the Lunacy Commissioners, renamed Board of Control in 1913). Meanwhile the generic nursing periodicals featured optimistic articles about modern treatments and integration with the broader nursing profession, overlooking the harsh realities of the job (McCrae, 2014). Despite its crucial role in care and treatment of the mentally ill, nursing has continued to be marginalised by historians of psychiatry and mental institutions, with advances attributed to doctors and policymakers rather than to those who looked after patients’ night and day. As Nolan (2012: 78) remarked, ‘this neglect speaks volumes about the power relations, professional hierarchies and class divisions that prevailed when psychiatric services were delivered in the institutions, but which still prevail’.

Nurses featured prominently in a narrative account of Severalls Hospital by sociologist Gittins (1998), but of the plethora of histories of British mental hospitals, few have been written by nurses. Inspired by the book (Worth, 2002) and television series *Call the Midwife*, personal accounts of women in careers such as nursing have become popular, particularly those describing experiences in deprived communities or oppressive institutional regimes. As Caine suggests, autobiographical writing brings obscure work into the wider public domain, illuminating the underappreciated role of women in social history (Caine, 2010: 105). Meanwhile there is growing interest among nurses in their past, with important scholarly contributions by the likes of Chatterton (2004) and Adams (2009). Gloomy portrayals of miserable servitude have been challenged by research such as by Streeter (2011), who revealed how nurses at Morganton State Hospital in North Carolina did much to humanise a monotonous regime, as in a ‘lavish celebration’ for the departing chief of the nurse training school in 1900. As nurses lived in the mental institution, they created a social environment, and the authorities were aware that an unhappy workforce would detract from patient care, and recruitment.

Through critical use of documentary evidence, this case study explores the occupational, social and living conditions of nurses in a British county mental hospital in the early twentieth century. Although Graylingwell Hospital was progressive in many ways, it was a product of its time and of the social and cultural context of the care and treatment of insanity (Wright *et al*, 2015). The period of this study was an important phase in the development of nursing, and also of the role of women (Wright, 2010). After a national training scheme was introduced by a corpus of medical superintendents, asylum nurses gained modest professional credentials, but they were also tempted by trade unionism, causing tension in identity and outlook (McCrae & Nolan, 2016). Graylingwell was inextricable from the broader *Zeitgeist* of the labour movement and radical social change, which had considerable impact on asylum management and working relations. The study generated a wealth of data, which were interpreted and distilled into core themes. Some terms in this paper are now outmoded, but it is accepted practice in historical writing to present language as used at the time.

**Opening of Graylingwell**

The original Sussex asylum at Haywards Heath had belatedly opened in 1859 in response to a statutory requirement that every shire in England and Wales provide care for the pauper insane (Gardner, 1999). The Local Government Act 1888 established county and borough councils, and as Sussex had been divided into East and West, each authority made plans for an asylum. These institutions opened at Chichester in 1897 and Hailsham in 1903, while the existing asylum was taken over by Brighton Borough. Arthur Blomfield’s design for the West Sussex Asylum followed closely the model of George Hine, the official architect of the Lunacy Commissioners. This layout comprised a crescent of double-decked, south-facing ward blocks, fulfilling the priorities of segregation and surveillance, while affording each ward fresh air and views of the grounds (Wise, 2013). The symmetry was slightly distorted by extra blocks on the female side; this was justified by the consistently higher number of women in asylums. Modest stonework adorned the reception facade, and the vast expanse of red brick and barred sash windows was partially relieved by yellow brick patterning. The men and women recruited to Graylingwell found themselves in a modern building, with some facilities beyond the means of the typical domestic dwelling. Electricity powered the asylum from the outset, the kitchen and laundry had the latest equipment, and telephones were fitted. Demand soon exceeded the capacity of 450, and in 1902 building was completed for an additional 300 beds (Kidd, 1902), including detached villas for convalescent and working patients.

Appointed as the first medical superintendent, Harold Kidd insisted that he would lead not a place of confinement but a hospital, which would be known by its locality of Graylingwell instead of the official title of West Sussex County Asylum (Kidd, 1899). After his previous experience as senior medical officer at Cane Hill, an enormous asylum run by London County Council, Kidd relished the opportunity to enact a more humane regime in a setting of more human scale. The Commissioners in Lunacy (1904) contrasted the well-tended gardens outside wards with the dreary, gravel-surfaced airing courts elsewhere. Patients were occupied in the kitchen, laundry, workshops or the asylum farm, which comprised 200 acres of arable and pasture land. Despite a minimal ratio of doctors and nurses to patients, and lack of effective medical treatment, many patients were successfully returned to the community. In one report Kidd (1911) claimed that 53% of the female patients had at least a fair prospect of recovery.

**Morality, gender and class**

Like other mental institutions, Graylingwell was a self-contained enterprise, providing a home not only for patients but also most of its staff. As in large department stores such as the London premises of William Whitely (Horn, 2006), a resident workforce enabled employers to forge an *esprit des corps*, while provision of bed and board kept wages low. Nurses and attendants (the latter term used for male nurses) slept in close proximity to patients, their sparse rooms adjacent to ward entrances. Occupants were prohibited from knocking a nail into the wall to hang a picture, and rooms were ‘liable to inspection at any time’ (West Sussex County Asylum, 1897). In 1905 a separate block was built for a few fortunate female nurses (Visiting Committee, 1907); this was a development ahead of its time, although it was necessitated by overcrowding rather than concern for nurses’ comfort. It was 1933 before a comfortable, purpose-built nurses’ home was provided.

Living conditions for ordinary staff contrasted with the luxuries reserved for officers. The matron, Miss Alice Barnes, had a suite of rooms off the kitchen court, while her assistants had single bedrooms and a shared sitting room (Kidd, 1898). Accommodation for the medical superintendent befitted his status as overlord: a substantial house linked to the main block by a covered corridor, with extensive grounds meticulously maintained by ground staff and supervised patients. Kidd lived there alone, attended by servants, until his marriage in 1903 to assistant matron Miss Mildred Johnson. He was aided by a resident medical officer on each side. While characterised by Scull and colleagues (1996) as the ‘masters of Bedlam’, medical superintendents such as Kidd were subject to the authority of the visiting committee; they were required to live in, and needed permission to spend a night off site (for example, to attend a conference). However, by the late-nineteenth century asylum doctors had gained collective strength through the Medico-Psychological Association (MPA), and increasingly their clinical expertise trumped lay administration.

Victorian attitudes towards potential immorality among working-class nurses persisted in the early twentieth century, as doctors and administrators strove to maintain a decorous institution. The matron was a matriarch, having absolute authority over her lower-class charges. In a highly class-conscious society, nurses of upper ranks were expected to ‘infuse the wards through which they walked’ with their steadfast morality (Steinbach, 2004: 25). Nurses and attendants, in turn, imposed moral discipline on patients, within a rigidly disciplined routine (Shepherd, 2014).

Despite buoyant recruitment in the early years, the female nursing staff at Graylingwell had a high turnover. Many probationers left before completing their training, including young women who had come from afar; for example, leavers in one year were from Queen’s County in Ireland, and from the north-east of England (West Sussex County Asylum, 1900). A main reason for this attrition was the restrictive environment. With 14-hour shifts and only one day off per week, there was scant leisure time. Nurses on night duty had one day off in a fortnight; their work was governed by the tell-tale clock, which enabled the medical superintendent to check their hourly rounds of the wards. To leave the institution a pass was required: nurses handed their keys to the hall porter, and their time of departure and return was recorded at the gate lodge. As Gardner (1999) concluded from his study of the original Sussex Asylum at Haywards Heath, female nurses had a harder life compared to their male peers, with a stricter regime, higher nurse-patient ratio and lower wages; such structures contributed to an annual average of thirty female nurses resigning.

Women were barred from marriage, while men could wed with permission of the medical superintendent, though this was normally limited to charge attendants. In one case in 1898, second-class attendant HC was summarily dismissed for trying to hide his married status (West Sussex County Asylum, 1898). Acting in *loco parentis* for young women leaving home for the first time, officers enforced sex segregation as strictly for staff as for patients. Sexual liaison was prohibited, on and off the grounds. In 1902 deputy head attendant DK was dismissed by Kidd for ‘misconduct with Nurse B while on holidays’, after he had ‘promised to make a very good Officer’ (West Sussex County Asylum, 1902). There were also several instances of young women leaving due to pregnancy (e.g. West Sussex County Asylum, numerous dates 1912-1914); perhaps they were unaware of having conceived prior to appointment, but it is also possible that clandestine couplings occurred during their employ. Sacking offences were many. Young nurse EC resigned while ‘under notice for carelessness’ after leaving doors and windows unlocked (West Sussex County Asylum, 1911). Some probationers were too physically weak for the work, while others were insubordinate or morally corrupt (among attendants, this was often related to alcohol). Another cause of staff wastage was military service. Men who had previously served in the army or navy were attractive to asylum management for their strength and obedience, but on outbreak of the Boer War, ten attendants were called to the colours as reservists (West Sussex County Asylum, 1899). Despite this, men were much less likely than women to resign. Extramural activities contributed to their loyalty; some were lured to the institution by the opportunity to play sport or music for the institution, such endeavours being prominent features of asylum life (Gardner, 1999).

The orderly routine at Graylingwell was dramatically disrupted by the war with Germany. With an enormity of casualties arriving on hospital ships from France, in 1915 the War Office requisitioned institutions for use as military hospitals. Asylums were ideal, as they were out of public sight, and their patients could be transferred elsewhere with minimal fuss. Graylingwell was one of those chosen, and over 700 of its patients were transferred to other county asylums, where they slept in halls or corridors. Under the jurisdiction of the Royal Army Medical Corps, Kidd remained at the helm, at the rank of Lieutenant-Colonel. The matron remained Miss Cole, who had replaced Miss Barnes in 1904. Cole, who was later awarded the Order of the British Empire for her service at the war hospital, led an increasingly female workforce as many of the men went to war. Nurse FS, who had left in 1912 for general nurse training, returned in 1916 as a night sister in the war hospital (West Sussex County Asylum, 1916). Despite exemptions from active service, conscription in 1916 led to further depletion in male workers, and while noting their patriotism, Kidd (1917) regretted the barely sufficient number that remained. Each annual report during the war contained an appendix in which Kidd carefully recorded deaths of attendants, whose sacrifice was later honoured by memorial windows in the chapel. Graylingwell continued to admit military casualties until 1919, when the War Office passed the hospital back to the county council.

An illuminating account of nursing in the war hospital is found in the letters of Marie Werder. Originally from Switzerland, Werder was appointed in 1915 and she wrote to the matron-in-chief in New Zealand (where she had worked previously) of how she and colleagues converted the asylum to a military hospital. ‘We worked all day and night and felt tired out,’ she recalled after the arrival of the first troop trains (Werder, 1915: 136). However, while the privations of war were relieved at Graylingwell by generous local donations for soldiers’ comfort (Wilson & Wright, 2016), the 700 dislodged mental patients experienced great hardship, and many never returned. Each cargo ship torpedoed in the Atlantic had an impact on asylum rations, and high mortality was compounded in institutions overwhelmed by the influx of patients transferred from war hospitals. Over two hundred beds were vacant when Graylingwell resumed as a mental hospital, and this was exploited. In 1922 contracts were made with Middlesex to take 30 women from Napsbury Mental Hospital, and with Croydon Mental Hospital for 30 male and 15 female patients (Hopper, 2012). When local admissions increased the guests were returned, and soon all was back to normal.

The hospital reverted to its former sex segregation, and it would be many decades before female nurses would work on male wards. However, traditional gender attitudes were challenged by wartime experience, and in 1920 the first female doctor arrived at Graylingwell. Octavia Wilberforce recalled how the nurses were ‘all very agitated and hated the thought of a woman doctor’, but she soon won over her critics and ended her term as *locum tenens* by joining in the festivities at the ward sisters’ new year’s eve party (Jalland, 1989: 131). She looked back on her time at Graylingwell as a ‘great joy’, negating dour images of life in mental institutions (Jalland, 1989: 125).

**Professionalisation or organised labour?**

When Graylingwell opened at the turn of the nineteenth century, mental nursing had entered a new era. By the 1890s the wider body of nursing was pursuing professional status, but Ethel Bedford Fenwick, who had founded the British Nursing Association in pursuit of state registration, had little respect for mental nursing. Fenwick asserted that ‘no person can be considered trained who has only worked in hospitals and asylums for the insane’, adding that ‘considering the present class of persons known as male attendants, one can hardly believe that their admission will tend to raise the status of the association’ (Adams, 1969: 12-13). Class bias is obvious here, but there was indeed stark contrast between the mannered middle-class women in the prestigious teaching hospitals and the coarse, uneducated asylum attendant. Yet the first national training scheme for nurses was in the asylums. After producing the *Handbook for Attendants* (popularly termed the ‘Red Book’), the MPA introduced the Certificate of Proficiency in Attending on the Insane. The first examinations were held in 1891 (Nolan, 1993), with written and oral papers and a practical test, marked by the medical superintendent and an external MPA assessor.

Kidd (1899: 18) noted that Graylingwell nurses were ‘individually anxious to acquire a thorough knowledge of mental nursing’, and the MPA syllabus was soon applied, with lectures by assistant medical officers (Kidd, 1900). Before starting this training, recruits prepared for the St John’s First Aid Certificate, using a manual known as the ‘Black Book’. Annual reports recorded the number of nurses taking St. John’s examinations; 73 candidates succeeding at first sitting (Kidd, 1899). After gaining the MPA certificate at Graylingwell, some female nurses were attracted to general nurse training. In 1906, for instance, nurses MB, AC and AP left for this reason, and they were followed by others (West Sussex County Asylum, 1906). This loss was felt at Graylingwell, where the female side was persistently understaffed. Clearly, some nurses had career ambitions that they did not think could be fulfilled in a mental institution, despite the positive intent of the Graylingwell management. As Shepherd (2015) suggested, training was a double-edged sword in mental hospitals, for it boosted the employability of nurses seeking a more rewarding career elsewhere.

Life for attendants and nurses was tough, but they had an advocate in the Lunacy Commissioners, who often criticised visiting committees for neglecting the interests of staff, as described by Palmer (2012) at the Cornwall Asylum. Meanwhile the working class was gaining collective strength through trade unions (Carpenter, 1988) and the unquestioning subservience of asylum staff could not be taken for granted. In 1895 two doctors and head nurse Laura Evans at Berrywood Asylum in Northampton founded the Asylum Workers’ Association (AWA), which pledged to improve working conditions (Morten, 1897). With a large workforce across the country to represent, the AWA could have been a firm platform for negotiating better conditions, but with membership open to asylum management it did not ‘rock the boat’. An early president was prominent alienist James Crichton Browne (1898), who emphasised medical leadership to prevent degeneration into ‘trade unionism’. Nonetheless, members were able to raise concerns such as excessive hours of duty (‘Veritas’, 1906): -

It is to my mind unreasonable that a man or woman should be compelled to work for 80 hours a week in the company of insane people. Yet, I am told that in many places the hours worked exceed that number, the weekly leave being, in a few cases, half a day weekly and a full day once a month, which means that on average 87 hours are worked.

Lobbying by the AWA was significant in the passing of the Asylum Workers’ Superannuation Act 1909, but the pension scheme was not always appreciated. In 1910 Lancashire asylum workers petitioned for extra pay to cover the deductions, and when this was refused a group of attendants founded a more assertive body, the National Asylum Workers Association (NAWU). At Graylingwell, Kidd (1910: 15) complained that the Superannuation Act had ‘displaced the excellent scheme drawn up by this Committee and sanctioned by the County Council. Some of the provisions of the new act bear hardly upon those members of the Staff who were engaged and served under the old conditions’. The result was that visiting committee agreed to increase salaries to cover the compulsory contributions (Visiting Committee, 1911); local discontent was thus ameliorated. Despite the reforms of Lloyd George’s Liberal government in these years, unrest was brewing around the country as trade unions flexed their muscles, while radical socialists, anarchists and Suffragettes threatened the social order. In 1913 a strike over working conditions was narrowly evaded at the West Riding asylums (Nolan, 1993).

After the horrors of the Great War, workers demanded a fairer deal in life, and the trade unions were their voice. By 1918 the entire staff of the Brighton Borough Mental Hospital had joined the NAWU (Gardner, 1999), but Graylingwell was not so represented, probably thanks to the charismatic management of Kidd. In 1919 the AWA disbanded, having failed to compete with the NAWU, whose membership reached 14229 (Carpenter, 1988). After winning agreement to a 60-hour week, the NAWU reached its pinnacle in 1922 at the ‘Battle of Radcliffe’. Nurses barricaded themselves in wards after the management of the Nottinghamshire Mental Hospital announced a reduction in wages. The strikers were eventually overcome by police, but although public sympathy was aroused, the union’s influence waned in the 1920s (Carpenter, 1988). Other strikes such as at Exeter were broken, with staff reduced to humiliating personal pleas for reinstatement (Douglas, 2015). The Trade Union Congress courted the nursing workforce, but this was resisted by the College of Nursing, which asserted itself as the true representative of the profession. From its *Nursing Times* podium, the College warned nurses of political exploitation (McCrae & Nolan, 2016). Graylingwell management emerged unscathed from union militancy; however, conditions for nurses were slow to improve, and recruitment was becoming more difficult.

In 1921 a sensation resulted from *The Experiences of an Asylum Doctor*; an *exposé* by Montagu Lomax of dilapidated and dirty buildings, a stultifying regime, awful food and excessive drugging and purging of patients at Prestwich Asylum. Lomax was scathing on the quality of attendants, many of whom were lazy and tyrannical, although he blamed this on their abysmal treatment by management. Having also criticised the doctors, he was dismissed in the *Lancet* and *British Medical Journal* as a junior officer naïve to mental hospital practice, but the revelations could not be swept under the carpet entirely (Hopton, 1999). The government appointed a committee to investigate the administration of mental hospitals. In its report in 1923, the Cobb Committee reported a medical superintendent’s opinion that it was not in nurses’ interests to reduce their working hours because they disliked free time: this was a vocation, not factory work. The voice of nurses was more accurately heard in another report following the Prestwich scandal (McCrae & Nolan, 2016). *Nursing in County & Borough Mental Hospitals*, the product of the first official enquiry into mental nursing, recommended a purpose-built nurse training school, lodgings set apart from the main buildings, and recreational facilities for staff. The report also argued for assimilation with general nursing, although a dissident, Doctor Henry Devine of Portsmouth Mental Hospital, feared a ‘hospital fetish’ diverting nurses from their true role:

An attendant who could organise cricket matches or a female nurse able to teach the two-step might often be of more use than one who regarded the duties of her or his vocation as being entirely along the lines of looking at the tongue and feeling the pulse (*British Medical Journal*, 25th April 1925).

Nursing in Britain reached an important milestone in 1919 with the introduction of the state registration and the General Nursing Council (GNC). The GNC introduced its own examination for mental nurses, parallel to the existing MPA scheme. Some medical superintendents insisted that only the MPA had the expertise to examine for the specialised work of the mental hospital, but Kidd (1924: 22) was pleased to report that in 1923 Graylingwell became a GNC training institution for male and female nurses. However, mental nurses passing either GNC or MPA examination were not classed as fully state-registered, being placed on a supplementary part of the register.

In 1924 a Royal Commission was established to review the laws and procedures relating to persons of unsound mind in England and Wales, chaired by lawyer Hugh Macmillan. Evidence was taken from administrators, magistrates, medical superintendents and patients, but nursing opinion was limited to interviews with one female probationer and one male attendant. The report (Royal Commission on Lunacy and Mental Disorder, 1926) called for radical change to a stigmatised system, and the resulting Mental Treatment Act, 1930 introduced voluntary treatment for people with treatable mental illness, for whom admission would be decided by doctors alone. To fulfil the objectives of this enlightened statute, modern buildings were needed, away from the oppressive atmosphere of the old block.

At Graylingwell an admission unit was built a hundred yards away from the main block. Intended as a treatment centre in its own right, with male and female sides each containing 40 beds, the new building looked more like a boarding school than part of a mental institution. Having a splendid aspect over greenery fore and aft, it had brightly furnished dining and sitting areas and pristine clinical rooms. Summersdale was officially opened on 27th April 1933 by Lawrence Brock, chairman of the Board of Control, who acclaimed Graylingwell as one of the best mental hospitals in the country, where ‘diseased minds’ would be treated like other illnesses (*Chichester Observer*, 3rd May 1933). The medical superintendent was now Cyrus Ainsworth, who had been appointed on 1st January 1927 after Kidd’s thirty-year reign. A changing legislative and social context enabled Ainsworth to fulfil much of his predecessor’s vision. Working relationships were nurtured with general practitioners and hospital doctors, who were ‘coming to terms with the changes in legal attitudes to the mentally ill’ (Ainsworth, 1935: 11). In 1933 voluntary patients accounted for 40% of admissions to Graylingwell (Visiting Committee, 1934: 6), and although specific medical treatments remained elusive, the recovery rate rose markedly after Summersdale opened. Only the best nurses were chosen for such units; the brusque manner of dealing with the certified insane was deemed inappropriate for the care of neurotic patients, many of whom were socially superior to the nurses (McCrae, 2014).

The Mental Treatment Act bypassed the denizens of the ‘back wards’, which Taylor (2014) described as ‘a byword for neglect and misery’. A particular affliction suffered by thousands within the asylum system (mostly men) was general paralysis of the insane. This condition was a late manifestation of syphilis, and Alexander Fleming had conducted experiments at Graylingwell in 1909 with the drug Salvarsan, but with limited success (Kidd, 1910). In the 1920s, following the discovery that fever induced by malaria could arrest the progress of this devastating disease, Graylingwell patients were sent to a special unit at Knowle Mental Hospital in Hampshire to be infected by mosquito bite. The treatment was a landmark in the history of psychiatry, although most cases proved beyond cure. Meanwhile schizophrenia, the great beast of insanity, seemed impenetrable (McCrae, 2006). The mental hospital population in England and Wales was rising by two thousand per year throughout the 1930s, yet progress was also made in the old block. Since 1922, when Saxty Good unlocked the doors throughout Littlemore Mental Hospital in Oxford, several other medical superintendents had tentatively opened their calmer wards (Clarke, 1993). In 1931 the Board of Control (1931:13) noted that several wards at Graylingwell were being ‘administered upon the open-door principle’, and that ‘parole beyond the estate is given to 16 men and 12 women and 20 other men and 25 other women have parole within the grounds’ (Board of Control, 1931: 9). The combination of legal changes, medical advances and more enlightened practice were slowly but surely changing mental hospital culture in the 1930s.

**Social advances**

Shortly before the completion of Summersdale, on 23rdNovember 1932 a nurses’ home containing 50 single rooms and communal areas was formally opened. ‘Ladies first’ was a pragmatic response to serious recruitment problems on that side. Rooms were small, and there was still a myriad of rules to observe (including prohibition of male guests), but nurses showed pride in their new residence (Ainsworth, 1933: 10). Some married men lived out, and a few houses were provided on the estate for charge nurses and their families, but for most of the male staff, home remained a ‘curtained cubicle’ next to the wards (Visiting Committee, 1924: 7). Not until the 1950s were male nurses given accommodation away from the sights, sounds and smells of their workplace.

On the ground floor of the new nurses’ home was a training school with lecture rooms and library. As in other mental hospitals, a tutor was appointed, with dual responsibility for the nurses’ home. Appointed as second assistant matron, Miss Ellen Cross prepared female probationers, while male probationers received tuition from the chief male nurse (Ainsworth, 1933: 11). The proportion of qualified nurses rose steadily, reaching an average of 30% in British mental hospitals by 1936, but candidates failing the examination were retained on the nursing staff, and wards were not necessarily under the charge of a qualified nurse until long after the NHS takeover in 1948 (McCrae & Nolan, 2016). Annual reports suggest that qualification was an expectation (although not a requirement) at Graylingwell.

The workforce was boosted in the 1930s. According to the annual report in 1929, the total nursing staff of 129 comprised 20 charge nurses (9 male, 11 female), 89 ordinary nurses (41 male, 48 female), and 6 male and 14 female night nurses. Over half of the 56 male nurses were qualified, but merely 19 of 73 women (Board of Control, 1929). By 1935 the nursing staff reached 179, with 47 men and 32 women qualified (Board of Control, 1935). However, this was barely sufficient for the number of wards and patients, and understaffing on the female side persisted. Whereas male-dominated industries suffered severely in the economic slump, drawing hundreds of men to secure jobs such as mental nursing, female recruitment problems worsened. Opportunities for women had expanded with the growth of clerical work and also production-line assembly, where lesser-paid female workers were preferred by employers over a unionised male workforce. The discrepancy between male and female nurses’ pay, based on the traditional ‘breadwinner’ rationale, was becoming indefensible – although in reality, pay parity was decades away. Compared to mental nursing, a young woman could work in a factory for more money, while maintaining her friendships and freedom. Throughout the 1930s the majority of recruitment advertisements by mental hospitals in the nursing press were for women. As shown below, Graylingwell offered local women a relatively generous remuneration in a market town with high employment.

*Figure 1*: Advertisement for nurses (*Chichester Observer*, 5th August 1939).

Gender differences were evident in Nolan’s (1993) research on nurses of the interwar period in their motives for mental hospital work. In order of importance, men valued a secure job, companionship, and sporting and musical activities; women gained most satisfaction from caring for patients, relationships with colleagues, taking pride in their ward and the weekly dances. However, as most of Nolan’s interviewees were people who had devoted their careers to mental nursing, we know less about why so many recruits left before completing their training. While men could settle on a job for life, the marriage bar curtailed the careers of female nurses.

Sport became more organised and competitive in mental hospitals in the 1920s and 1930s. In interview, applicants who could contribute to the success of the football or cricket team were favoured. From autumn to spring Graylingwell was represented by its football colours and in summer by flannels, caps and blazers adorned with the hospital crest. Unlike elsewhere in the south-east of England, where teams competed in mental hospital leagues, Graylingwell participated in the West Sussex League, showing its local integration. One of its keenest rivals was the meat paste factory Shippams, another large employer in Chichester; matches such as the Chichester Charity Cup Final in 1932 drew large crowds (*Chichester Observer*, 20th January 1932).

Women also enjoyed the sports facilities, with tennis a popular pastime. As well as regular dances, the main hall was used for cinema shows, attended by patients and staff. Musical talent was coveted and Kidd and his successors boasted of the quality of the band and choir. In the early years the band was conducted by assistant medical officer Ernest Sall (Kidd, 1902). Like footballers, bandsmen were excused from normal duties for playing or practising, and they also received a bonus for public performances. Music and drama were also means of integrating with the local community. Outsiders came to watch shows, and amateur dramatic societies added to home-grown talent (Ainsworth, 1935). With reduced working hours, better residential and social amenities, and the beginnings of liberalisation of the traditional regime, life was not so bad for Graylingwell nurses.

**Conclusion**

Nurses at Graylingwell worked in arduous conditions, yet their lives were more colourful than the monotonous drudgery portrayed by conventional mental hospital histories. These institutions were remarkably similar in operation and culture, but there were also differences. Whereas other county asylums were remote from the centres of population, Graylingwell was always part of Chichester, employing local people and maintaining close links with the community. It appears relatively forward-thinking, but we should be wary of the limitations of sources. Nurses’ perspectives are missing from official records, and it would be dubious for Kidd to take all credit for advances in nursing in the period covered here. Arguably, the hospital authorities did well to maintain staff harmony despite the hardships of living and working at Graylingwell. Kidd showed himself to be a competent manager, who sought to mitigate any financial disadvantage to staff as a result of pension legislation, which probably contributed to the lack of union agitation at the hospital. Following his retirement, one patient’s relative wrote to the local newspaper on how Graylingwell provided ‘a real well of healing’ in which the distressed and vulnerable could find a degree of peace and quietude (*Chichester Observer*, (1933: 2).

The early years of Graylingwell coincided with the emergence of training and collective representation, which combined to raise the status of mental nurses across the country. Hagiographies of ‘great men’ abound in historical accounts of the mental hospitals (Scull *et al*, 1996), and while Kidd was undoubtedly a humanitarian leader with a clear sense of vocation, he also had a position of privilege which allowed him to boast of his achievements and embellish his legacy. We should also avoid a simplistic, Whiggish notion of progress. As the Graylingwell population rose, typically a single qualified nurse ran a ward of fifty patients from dawn to dusk. In the absence of effective drugs this was no job for the faint-hearted; shifts were arduous with little time for recuperation. Nonetheless, mental nursing offered stability while affording a modicum of social life. By the 1920s, nurses at Graylingwell were benefiting from better status and conditions, and while much of these changes arose from external forces, the hospital was at the vanguard in its provision of a nurses’ home. Soon all would change again, as war was declared in September 1939, and a new chapter would begin in the story of Graylingwell. In the 1950s it gained international renown for its pioneering community service, led by medical superintendent Joshua Carse, an innovation that would ultimately signal the demise of the mental hospital (Wright *et al*, 2016).

Interesting contrasts may be drawn with the conditions and challenges faced by mental health nurses today. By modern standards, the Graylingwell environment was austere, segregated and strictly disciplined. Yet despite the restrictions of institutional life, morale was probably no worse than that of today, if not higher. The homogeneity of nursing when everyone worked and lived together is very different to the diversity and fragmentation of services today. A recurring theme is the tension between the specialism of mental health and identification with the broader profession of nursing. While community nurses work interchangeably with other mental health disciplines, generic nurse training is being mooted, and the new curriculum will reduce the mental health component. As with many progressive policies, the law of unintended consequences (Merton, 1936) looms. The concept of asylum has been neglected, and a clinical, target-driven orientation in mental health nurses may detract from their role in providing a nurturing social environment for patients’ recovery.

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