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How to cite:
Millard, David; Agulnik, Peter; Armstrong, Neil; Fees, Craig; Hall, John; Kennard, David and Leach, Jonathan (2022). Innovation in mental health care: Bertram Mandelbrote, the Phoenix Unit and the therapeutic community approach. History of Psychiatry (Early Access).

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Version: Version of Record

Link(s) to article on publisher’s website:
http://dx.doi.org/doi:10.1177/0957154x221142416

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Innovation in mental health care: Bertram Mandelbrote, the Phoenix Unit and the therapeutic community approach

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Abstract  
Bertram Mandelbrote was Physician Superintendent and Consultant Psychiatrist at Littlemore Hospital in Oxford from 1959 to 1988. A humane pragmatist rather than theoretician, Mandelbrote was known for his facilitating style of leadership and working across organisational boundaries. He created the Phoenix Unit, an innovative admission unit run on therapeutic community lines which became a hub for community
outreach. Material drawn from oral histories and witness seminars reflects the remarkably unstructured style of working on the Phoenix Unit and the enduring influence of Mandelbrote and fellow consultant Benn Pomryn’s styles of leadership. Practices initiated at Littlemore led to a number of innovative services in Oxfordshire. These innovations place Mandelbrote as a pioneer in social psychiatry and the therapeutic community approach.

Keywords
Bertram Mandelbrote, institutional innovation, Littlemore Hospital Oxford, Phoenix Unit, therapeutic community

Introduction

Human endeavours, it seems, are forever poised between catching dreams and coaxing materials. In this tension, between the pull of hopes and dreams and the drag of material constraint, and not in any opposition between cognitive intellection and mechanical execution, lies the relation between design and making. It is precisely where the reach of the imagination meets the friction of materials, or where the forces of ambition rub up against the rough edges of the world, that human life is lived. (Ingold, 2013: 73)

This article describes the innovative work at Littlemore Hospital which was led or supported by Dr Bertram Mandelbrote during his tenure, initially as Physician Superintendent from 1959, and then as Consultant Psychiatrist from 1974 until his retirement in 1988. The central focus of this work was the creation of the Phoenix Unit and the development of the associated practices within what was called the ‘A’ Division of the hospital. Other innovative developments also took place in Oxfordshire during this period which were related to Mandelbrote. We draw on evidence from Mandelbrote’s oral history and witness seminars, as well as written accounts, that provide a picture of how change was initiated both in the hospital and in the local community. Medical innovators might be thought of in Weberian terms as charismatic leaders, whose innovations face the threat of stagnation as their authority is routinised. This is broadly how Manning (1989) characterises the therapeutic community movement. Wilson (2012) makes a similar case. Such a schematic approach enables comparison and an orderly historiography. But, as Micheli (2019) points out, it also risks oversimplification, even where the personal agency of a key individual is critical, as with Basaglia in Italy. By drawing extensively on Mandelbrote’s own recollections and the personal memories of those who worked with him, we recognise how complex personal influence can be, and seek to develop a nuanced account of how Mandelbrote came to lead innovation in Oxfordshire.

Mandelbrote is often presented as a key figure in the Therapeutic Community movement (e.g. Pearce and Haigh 2017: 22). This might seem to suggest that he is best understood as a person whose influence consisted in implementing or disseminating ideas. Kennard (1998: 40), for example, described him as playing a leading role ‘in the application of therapeutic community principles in large institutions’. This, however, is a retrospective picture. Our material suggests that although he was aware of, and sympathetic towards, the emerging therapeutic community movement, Mandelbrote was primarily motivated by a desire to make mental healthcare more humane. He is better seen as a pragmatist, who perhaps felt what Kennard (1983: vii) called the ‘therapeutic community impulse’. Indeed, Mandelbrote’s pragmatic approach was what characterised ‘therapeutic community’ during this period when the term was seeking roosting places, still free-floating, and theory was chasing after a phenomenon in motion to try to get it to stand still. It is not that the new ideas about mental healthcare institutions played no role. Rather, we suggest, Mandelbrote’s most important contribution was to initiate and support change, both in
the hospital and in the local community. He achieved this by creating conditions favourable to the evolution of innovative institutions and professional practice in which those new ideas played out.

The results are best characterised not primarily as the implementation or application of therapeutic community principles, but as a series of relatively unplanned, bottom-up initiatives that reflected therapeutic community sensibilities, priorities and commitments, but which also reflected his confident exercise of authority. In Ingold’s terms, drawn from the quotation that opens this paper (Ingold, 2013: 73), Mandelbrote was less a designer of mental healthcare institutions than a maker, working not from a masterplan or over-riding vision but engaging piecemeal with the rough edges and constraints of the world. Practical and organisational skills led to his helping to create institutions or services fit for the people they served.

Although we are cautious about characterising Mandelbrote as a charismatic leader, we do argue that personal qualities – rather than beliefs or theoretical commitments – constituted a large part of his influence. Understanding Mandelbrote means recognising that he worked against the grain. He was a defender of the possibility of humane hospital care at a time when the Zeitgeist was increasingly anti-institutional. Although keen to develop continuity of clinical care and to support innovative community-based projects, he was not interested in community psychiatry per se and liked to work from a hospital base. His capacity to resist the dominant trend speaks to his disposition. His influence, we suggest, consisted of two interlinked qualities of character: a capacity to bring people together by encouraging initiative, trust, cooperation and mutual effort; and by managing, even controlling, the internal and external boundaries of those parts of the organisation for which he held responsibility such that he could contain the anxieties of the professional staff with whom he worked. These characteristics, coupled with skills in networking, were to be highly impactful.

**Methodology**

As exemplified by Turner et al. (2015), we make our argument through reflective analysis of personal experience, oral-historical material, and archival and published sources. As set out in the introductory paper (Hall et al., 2023), the research methodology grew piecemeal in an unplanned way from a range of encounters spread over a number of years, in which the authors who formed the research group had met one another in work settings. This led to a common view that what they had observed as having taken place in Oxford in the defined period of time was of interest, and should be recorded as examples of innovative practice and known more widely. A key means of achieving this was by recording the memories of those who had taken part in the constituent services.

The anchoring point has been the Planned Environment Therapy Trust (PETT) Archive and Study Centre (1989–2018), abbreviated hereafter as the PETT Archive. The collections, site and plant were transferred to the Mulberry Bush Organisation at the end of 2018, and renamed The Planned Environment Therapy Archive and the Mulberry Bush Third Space (MB3) respectively. The collections hold a unique and internationally significant body of materials related to therapeutic communities and other enabling environments. The Archive collected academic papers written by Bertram Mandelbrote and associated material. The latter includes two oral history interviews with Mandelbrote conducted by the archivist Craig Fees in 1995 and 1996, in which, following his retirement, Mandelbrote reflected on his own career.

We also organised and drew on oral histories collected through witness seminars and individual interviews (Tansey, 2008). Four witness seminars were held in 2014 and 2015. The participants were individuals known to several of the authors and whose careers had included some significant involvement with Bertram Mandelbrote. Many already knew each other well. Meetings included structured questioning and spontaneous interaction. Sessions were recorded and transcribed.
Printed transcripts were returned to all participants, who were invited to edit their own contribution for purposes of clarity. In addition, and making use of a Wellcome-funded pilot project ‘Reconceptualising Recovery’, a research assistant took part in the witness seminars and also interviewed eight individuals who offered differing perspectives of Mandelbrote, and the developments that sprang from his initiatives. Those interviews further informed this and related papers derived from this research. The recordings and transcripts edited by the contributors are held at the Archive.

A further witness seminar/reunion of former Phoenix Unit staff was held in October 2016 at the PETT Archive and Study Centre, from which much of the material in this paper is drawn. There were 23 participants, including working and retired psychiatrists, medical psychotherapists, nurses, a clinical psychologist, social workers, an occupational and an art therapist. Collectively their experience of the Phoenix Unit covered the period from 1965 until Mandelbrote’s retirement in 1988. There was a lot of mutual recognition among the participants, reflecting the varying lengths of time participants had been associated with the unit or the hospital’s A division. The reunion consisted of six recorded and subsequently transcribed and edited sessions totalling just under six hours. The recordings and transcripts, edited by the contributors, are held at the PETT Archive. Greater detail and a critique of the reunion is to be found in a paper by Armstrong (2018) reflecting on clinical expertise in a bureaucratic age. The recordings were also made available to Leach, who comments on the ‘chaotic’, ‘mad’ ambience of the unit (Leach, 2019). Our aim throughout was to base our analysis on personal experience, intended to develop a more nuanced history illustrating Mandelbrote’s personal impact and influence.

Dr Bertram Maurice Mandelbrote

Bertram Mandelbrote (1923–2010) (widely referred to as ‘Bertie’) was born and brought up in Cape Town and trained in medicine at the University of Cape Town. In 1946 he came to Oxford as a Rhodes Scholar investigating abnormal copper metabolism and then moved to the Hammersmith Hospital in London, where he obtained his MRCP. He subsequently moved to the Maudsley Hospital to train as a psychiatrist and became Senior Registrar there to Aubrey Lewis. After a year spent at McGill University in Montreal, in 1954 he returned to the UK and continued his training at Warlingham Park Hospital, Surrey, with TP Rees; at the time, this was one of only a very few ‘open door’ hospitals operating in Britain. Rees was to have an influence on a number of progressive psychiatrists who trained under his wing. Among these was Denis Martin, who as Physician Superintendent of Claybury Hospital became influential in the movement to change the traditional mental hospitals of the era into therapeutic communities (Martin, 1962).

In May 1956, Mandelbrote became Physician Superintendent at the Coney Hill and Horton Road Hospitals (which were adjacent to each other) in Gloucester at the early age of 32. The hospitals were in very poor condition (Hollingsbee, 2002). During Mandelbrote’s tenure of his Gloucester post, he had the full authority of a physician superintendent under the 1890 and 1930 mental health legislation, with oversight of all aspects of day-to-day practice. He used his powers to institute rapid changes in the prevailing custodial culture, so that within six months of his arrival the two formerly ‘closed’ hospitals were ‘open’ with unlocked doors (Mandelbrote 1958, 1965). He reflected in retirement:

I had by that time already got a fair idea of what I wanted to do. As I say, I was arrogant, and I felt I knew the answers to things, and I was energetic and enthusiastic and there were things I wanted to do . . . First of all I felt that . . . we needed to classify people along behavioural lines. I felt that nurses should be out of uniform, I felt that men and women should be in mixed units. I felt it was very important to move people from the people that were looking after them, so that they were in contact with new faces, and began afresh.
to that extent. I felt that communication at all levels was terribly important, so we had a system of meetings and groupings, where all the people in various sort of categories had opportunities of meeting and communicating, discussing things. I met every day with all the staff members, and the outside social workers, mental welfare officers and so on. We discussed all the problems that were presenting at the time. We discussed ideas. (Mandelbrote, interview, 1995, TC Voices/138)

There were many other innovations. Among the more important was the development of the hospitals’ League of Friends, and harnessing the interest of influential local people. New out-patients were set up within the catchment area, with nurses – in the absence of hospital-based social workers – taking on new roles of support in the community, and linking them with general practices. Mandelbrote regarded their work as the beginnings of community psychiatric nursing. The pressure on beds was resolved by introducing screening of all new referrals for admission by domiciliary visits.

The opening of locked doors at a small number of pioneering British mental hospitals had aroused interest in the USA. In 1957, three separate study tours were conducted by a number of senior psychiatrists from New England. These included a visit to Mandelbrote at Gloucester. The tours were later the subject of a conference review (Gruenberg and Boudreau, 1960). Ernest Gruenberg, an eminent psychiatrist, and sometime Professor of Public Health at Johns Hopkins University and known for introducing the concept of ‘The Social Breakdown Syndrome’ (Gruenberg et al., 1972), played an important role in these visits. The rapid changes Mandelbrote had introduced in Gloucester commanded interest, and led to return speaking engagements in mental hospitals and other mental health settings in the USA. Further contact with Gruenberg continued when, in 1959, after only three years at Gloucester, Mandelbrote moved to Oxford as Physician Superintendent of Littlemore Hospital.

Thus, when he took up this post, he already had a track record of transforming institutional cultures, and an international reputation. One indication of his wider connections was his relationship with the British Minister of Health from 1960–63, Enoch Powell, who cited Mandelbrote as one of two psychiatrists who were his ‘pals’ (Powell, 1988).

**Innovation at Littlemore**

Reflecting in his 1995 interview on his move to Oxford in 1959, so soon after instigating such major changes at Gloucester, Mandelbrote said:

. . . and then the vacancy occurred at Littlemore, and I was very eager to get back to Oxford, because whilst I enjoyed enormously what I was doing in Gloucester . . . I think it was an idea that I’d be attached to the university, with scope for teaching medical students . . . and I would also have a smaller hospital but an interesting hospital, which was in the centre of the community, where one could develop things.

Within a short space of time, Mandelbrote set about introducing the type of changes he had introduced at Gloucester. Thus, within months of his arrival at Littlemore the Commissioners in Lunacy noted in their 1959 visit that:

. . . the question of improved classification had also been much in Dr. Mandelbrote’s mind and a great deal of regrouping has already taken place . . . Patients are very well occupied . . . although the various occupation centres are so widely scattered as to make the task of the head OT a difficult one, there are no fewer than 8 trained OTs as well as a trained technician.

The only other consultant on the staff at Littlemore was John Duffield, a traditional psychiatrist, who Mandelbrote described as ‘an extremely difficult person to work with’ and ‘insisted on
having single sex locked wards’. Shortly after Mandelbrote’s appointment, they were joined by Felix Letemendia, who had been a friend of Mandelbrote when they trained together at the Maudsley Hospital, and who had previously worked in a research capacity with Mayer-Gross in Birmingham. Primarily interested in a biomedical approach to psychiatry and in sponsoring research into alcoholism, drug dependency and chronic schizophrenia, Letemendia had little interest in, and disputed the efficacy of, therapeutic community concepts (Crammer, 1996; Letemendia, Harris and Willems, 1967).

The adoption of a therapeutic community approach was considerably influenced by the appointment of Benn Pomryn as Consultant Psychiatrist and Deputy Physician Superintendent shortly after Mandelbrote came to Oxford. He was not a widely known figure and, following his death on 29 October 1982, Mandelbrote himself wrote an obituary:

Benn Pomryn was a quiet, unassuming, gentle person, deeply loved by his patients, many family doctors and close colleagues. He never felt the need of an office, bringing his services to the patient in the ward or to the general practitioner in the health centre or the patient in the community. His help and support in the early changes and reorganisation at Littlemore Hospital were deeply appreciated. (Mandelbrote, 1983)

Prior to his appointment at Littlemore, Pomryn had for a short time held a consultant post in Yorkshire. Qualifying at Westminster Hospital in 1939, he was an RAF Medical Officer until 1946 after which he worked with Maxwell Jones at Belmont Hospital, Surrey (subsequently renamed Henderson Hospital) for 11 years. He thus brought with him the experience of extensive working with the leading pioneer of the therapeutic community movement. Pomryn’s in-patient work was exclusively on the Phoenix Unit, where he was a constant presence. He played an important part in developing community services, such as weekly evening ‘clubs’, in nearby towns. He also worked closely with local general practitioners in surgeries, setting up supportive groups similar to those described by Michael Balint (1964). Pomryn himself was not an academic; his limited publications were all on aspects of therapeutic community practice (Pomryn, 1952; also Baker et al., 1953; Pomryn et al., 1956).

The Littlemore A and B Divisions

The different approaches between what could be regarded as mainstream, biomedical psychiatry and the therapeutic community approach led Mandelbrote to divide the hospital into the A and B Divisions. Two clinical ‘firms’ thus emerged, with a cross-section of patients representing every type of psychiatric problem, and it was agreed that continuity of care would be provided by each division. The main hospital building at Littlemore was already divided into two wings: historically, male patients had occupied one wing, females the other. The A Division moved into the former female wing and the B Division into the male wing. Mandelbrote stated that the change involved 681 patients being moved to different wards according to behavioural criteria. Despite the scale of the change, he recalled this as having taken place ‘over one day’ (TC Voices/138). Nursing teams followed this split, symbolised by the nursing staff of the B Division continuing to wear uniform in keeping with the white coat worn by Duffield. On the A Division, the historic gender separation was changed to a pattern of mixed male and female wards. None were locked. It was not until Mandelbrote’s retirement nearly 30 years later that the distinction between the A and B divisions finally disappeared.

All the wards allocated to the A Division, including those which served the needs of people with severe and enduring disorders and also the elderly patients, displayed various aspects of the influence of a therapeutic community approach to psychiatric care. By 1961 the acute admission area
within the A Division had been renamed the Phoenix Unit, and Mandelbrote was able to announce this formally in his report to the Hospital Management Committee:

At the beginning of 1961 . . . we embarked on an experiment of linking four wards into a small community. Approximately 100 men and women live in these four wards (Phoenix Unit). They are so grouped that the maximum nursing skills of the community can be mobilized to meet the needs of the more disturbed patients as they arise. Two wards are small (15 beds each) and can provide intensive nursing supervision of small groups if necessary. In this way patients can be admitted, have treatment and continued resettlement in an area which is moulded to meet their changing needs. The community is becoming a homogenous group of people irrespective of their length of stay in hospital with the same basic aims and goals. Linking wards together in this way has led to an increasing understanding of mutual aims by the nursing and medical staff working in this area, and a marked reduction in administrative duties with increasing acceptance of responsibility by the patients. (Physician Superintendent’s Report 1958–61: 48)

A small number of experienced nurses, who had enjoyed greater freedom to develop their roles at Gloucester within the hospital and in the community, chose to move with Mandelbrote to Oxford. This facilitated the introduction of the new nursing culture that had been established at Gloucester. To quote Mandelbrote again:

I had in fact trained some very competent people. There was one chap, called Helmut Leopoldt, who was a staff nurse. At that time the nursing hierarchy was very, sort of, rigid. And the prospect of movement very small indeed. And this chap, a staff nurse, had no prospect of anything at all. And I picked out a series of people to do six months of social work, because we didn’t have any social workers at Gloucester. And Helmut Leopoldt was one of the people I picked out. And he subsequently came with me to Oxford, became a rehabilitation officer, then became in charge of most of the nursing organisation and wrote a number of very good papers on the development of hostels for patients, community nurses, rehabilitation programmes. (TC Voices/138)

Following the retirement of Duffield, and with Letemendia moving to Canada in 1975, there was a considerable cultural change on the B Division. The latter’s successor, David Julier, relocated the B Division acute admission unit from the main Victorian hospital to the more modern Ashurst Clinic, on the other side of the road to the main hospital. More eclectic in his practice, Julier and his nursing team adopted some of the features of the therapeutic community approach, such as regular community meetings, and nurses abandoning uniform. In addition, a number of B-side nurses joined Helmut Leopoldt’s team supporting the group homes project. These changes were also facilitated by the appointment of Seamus Killen to the post equivalent to Chief Nursing Officer for the now managerially joined Littlemore, Warneford and Park Hospitals. He had previously worked at Fulbourn Hospital in Cambridge, and was influenced by the changes initiated there by David Clark as described in his influential book Administrative Therapy (1964). That impact was further enhanced by the appointment in 1980 of Geoffrey Pullen as a Consultant Psychiatrist to the vacant B Division post. He had also worked at Fulbourn and has written on his work – influenced by Clark – on the Street Unit at Cambridge, and of his personal journey leading to the creation of the Eric Burden Community, a therapeutic community for the treatment of young adults with psychotic or borderline disorders (Pullen, 1999).

The Phoenix Unit

A view of the experience of working on the Phoenix in the late 1960s has been provided by John Robinson, who was then completing his psychiatric training as senior registrar on the Unit.
Later, with Mandelbrote’s encouragement, he specialised in the psychiatry of old age, and became the first consultant in Oxford to specialise in old age psychiatry (Robinson, 2012: ch. 10). Robinson describes how the Phoenix Unit held daily meetings of the whole community of patients, doctors, nurses and anyone else involved, each morning from 8.30 to 9.30 a.m. An appointed chairman would read out reports of the night and of the previous day:

In my time the chairman was a patient who had been a professor in the university. There was also a secretary. The object of the meeting was to review the happenings of the previous twenty-four hours. No visible distinction was made between members of the community, no uniforms or badges were worn. Your authority depended upon the quality of your contribution, rather than your hierarchical rank. This could be somewhat disconcerting . . . This community meeting was followed by a staff group, in which their perceptions, reactions and feelings could be discussed and support could be provided. Later in the day were working groups and occupation groups. An assessment group considered the problems of new patients and how difficult behaviour could be contained. Crisis groups could be convened to resolve other difficulties, whilst relatives’ groups were held in the evenings. (Robinson, 2012: 114–15)

Working in the A Division had a distinctive character: informal, egalitarian and open. At a Phoenix Unit Reunion Witness Seminar in 2016, former staff of the Unit (indicated by initials below) recalled their vivid experiences of a working life that was remarkable for its lack of structure:

We didn’t have intensive care units there. We didn’t have seclusion rooms – the doors were open, everybody was there. So, if somebody was really very psychotic and ill, they were nursed and protected and kept safe in their room. And it wasn’t like these days, when somebody’s on one-to-one observation, where there’s just somebody sitting in a chair outside the room, and the person’s left in the room, and they are outside reading the paper – that’s what happens now and it’s just horrific to see . . . But there we were all sort of part of it, so everybody used to go and see how that person was getting on, and go and talk to them, and there was this sense of togetherness. (DT, CF1162)

And I think that . . . there was a benefit to having people . . . in the day, who’d recovered . . . and so were sitting in the unit saying, “I’ve got better. I was as bad as you, but, – you know, – look, – you can get better.” That was part of what went on – that you had people come back in the day, who were now living in the community, and would come . . . back to the group. (NB, CF1161)

What did happen was, you had people who were able to express themselves. They weren’t drugged up to the eyeballs, they weren’t managed – macro managed or micro managed, it all happened throughout the day, and the night. (JB, CF1162)

. . . but a lot of this is about empowering – helping empowering people, families, or patients themselves, to manage difficulties. And what the Phoenix was doing is actually challenging people about taking some of that responsibility, rather than expect the doctors or nurses to treat them. (SC, CF1164)

One thing that struck me, as a student nurse, to start with, was that although I was just a student nurse, not even finished my training, I was able to make a contribution. In fact, everybody was able to make a contribution to these meetings, and it seems to me very much a learning situation for staff, as well as patients together. (SC, CF1162)

Medical leadership

Some sense of the distinctive and complementary styles of Mandelbrote and Pomryn emerges from the recollections of staff who were directly or indirectly accountable to them:
Bertie . . . he kept calm about it . . . lots of people doing stuff, and he was sort of the still centre, which enabled it to happen, and, very importantly, he didn’t make you feel bad . . . and he had a good eye for who he chose, but the staff did do good things, and if things went wrong – there was no enquiry. (DK, CF1163)

And there was Benn, a brilliant man, in the middle of it all . . . no sort of hierarchy, no control, he allowed people to be who they were, and he was in the middle, . . . a sort of inconspicuous bloke. I remember he used to wear a Harris tweed jacket and brown trousers, and you thought: ‘Who is this guy?’ And then Bertie would turn up every so often, and he’d be in a suit so there was a difference between Bertie and Benn. (JB, CF1162)

Bertie paid particular attention to people who he had identified as culture carriers. So, that’s why he would take nurses out often . . . And, I think, when junior doctors came in on a rotation, often it – I think it was made fairly evident to them, that they would get their – a lot of their teaching from the nurses . . . and some people didn’t like that, and some people were very happy with that. (JK, CF1164)

You got used to reading what was going on, people’s body movements and what was being said, and nudges and winks, and people getting up and walking off, or – you got used to all that sort of stuff, and Benn could read all that, incredibly well. He didn’t, on the whole, believe in medication, or electrical convulsive therapy, or anything like that. He’d – he was much happier letting people . . . express themselves. (JB, CF1164)

Now, Bertram – you got back to seeing the person . . . as a person . . ., he always was hopeful that people . . . would ultimately fulfil themselves as well as they could. He didn’t like labels – he’d never talk about a psychopath. He’d talk about a person with personality difficulties . . . So, respect and . . . the fact that everybody had a contribution to make . . . everybody had their part to play, and that was the teaching of Benn Pomryn . . . – he was the therapist, really, rather than Bertie. Bertie provided an umbrella under which we could all do our own thing . . . And he’d have lunch with the hospital secretary and sorted out all the admin, and we could get on with our jobs. But, Benn, of course, he was the – he was very much the therapist . . . (JR, CF1162)

You had to be really sharp and really on the ball, with huge levels of responsibility, but we shared – it was shared as a team. And I found Bertie was very approachable. You could go to him and ask him, and phone him up at home . . . if you were really concerned about somebody. And he would – he wouldn’t hesitate to bypass [laughs] a junior doctor and do that, because it was saying experience, years working on the community, outweighed any other kind of hierarchy. But I think that teamwork was a really important part and understanding what the principles were behind the unit, and where the limits were. (JK, CF1161)

The above quotations give a glimpse of the Phoenix Unit and its two consultant psychiatrists at work. They had very different personalities and leadership styles. Whatever their commitment to the ideology of the therapeutic community as a treatment modality, it seems quite clear that both of them believed in the importance of providing a thoughtful humane culture of enquiry, in which people were encouraged to ‘find their voice’ and to exercise as much personal responsibility for themselves and for their community peers as their mental health conditions would allow.

An important aspect of Mandelbrote’s role was the creation and maintenance of a friendly, facilitating environment. For example, Mandelbrote instituted a regular multi-disciplinary A Division Senior Staff meeting, initially weekly but eventually three times a week. Key people with hospital-wide authority, such as the hospital secretary and the chief nursing officer, also attended, as did the head of the Nurse Training School and the head Occupational Therapist for the hospital. The meeting had important planning functions and in itself modelled Mandelbrote’s vision of a non-directive, facilitating leadership.
In his oral history interviews with Craig Fees in 1995 and 1996, Mandelbrote described his initial interest in the concept of the therapeutic community:

I was interested in the work Maxwell Jones was doing. I was interested in his initial work with effort syndrome and the neurosis group during the war, and I was interested in the work he was doing in Belmont which was mainly in relation to neurosis and personality disorder. (TC Voices/138)

... I mean my concept of it is first of all it's a way of changing institutions which are fairly fixed and rigid, opening them up to the extent that people in the institution participate and begin to take responsibility for themselves, and begin to look at the range of problems that they have, and devise ways of solving these problems. (TC Voices/168)

The modus operandi of the two consultants were in many ways complementary. Mandelbrote maintained many of the trappings, such as ward rounds, familiar from conventional psychiatry, while Pomryn was less formally engaged, allowing decisions to emerge from the various patient and staff groups on the Phoenix Unit. Although both attended the A Division senior staff meetings, they were very much thought of as ‘Bertie’s meetings’ in which Mandelbrote had a presiding function. If this was clearly hierarchical, he also created an atmosphere that encouraged open communication and an environment in the A Division in which staff felt protected.

Perhaps one of his greatest assets was his willingness to investigate and support new ideas as they emerged. He encouraged staff to widen their experience and take on new roles. This was particularly important for nursing staff. He was very aware that although a decision concerning admission, whether formal or informal, was a medical decision, it was the nursing staff who had to bear the day-to-day responsibility of looking after the person in the ward setting after admission. It was the nursing staff who were aware of the range of stresses which might be operating at a particular moment, and which might influence the ward milieu. Mandelbrote also thought it important to make an assessment in the patient’s home environment. As a consequence, it was a part of his practice to arrange, whenever practicable, for a ward staff member to accompany him to the domiciliary setting, with the advantage that that staff member was able to convey to others on the ward much more of the setting in which the illness had arisen. An important spin-off was that the staff member had crossed the boundary into community care and, where appropriate, ward staff could also be deployed to support the patient back into the community.

Mandelbrote recognised the importance of continuity of clinical care. It was an important element of the Phoenix Unit culture that as patients got better and no longer required in-patient care, they could go home but still retain links with the ward as a day-patient. Once known to the unit they were thus a ‘Phoenix patient’ who at times of crisis could ask to be seen on the unit, and where necessary ‘gusted’ overnight until either readmitted or continued for a time as a day-patient. This arrangement also had an important further function in that returning day-patients were bearers of the unit’s culture, often carrying out important roles in the day-to-day running of the unit, including sometimes helping in the care of more disturbed patients. Rather than being exploitative, this exercising of meaningful responsibility could be seen as ego-building and therapeutic.

**Influence on personal and professional development**

The experience of working on the Phoenix Unit and within the A Division had a profound effect on the professional development and subsequent careers of NHS staff coming under its influence. The following quotations from the Phoenix Reunion Witness Seminar (2016), and related written documentation, give some indication of how the seeds sown reaped a harvest in ensuing years:
I saw opportunities for getting staff and managers to talk to each other, so – because communicating and
talking always helps to overcome prejudice and misperceptions of other people’s intentions which people
always have. So, the thing I took away from Phoenix, yes – establishing forums for communication is
always a good idea. (DK, CF1164: p. 2)

The Phoenix Unit was the only model that made any sense to me, for organising an inpatient service. It was
the only meaningful model that gave a humane environment for patients, and an opportunity for staff to
flourish. All the other models that exist, if they are models, seemed very disappointing. (CB, CF1164: p. 2)

And very much . . . the influence that Bertie and Benn Pomryn – going out to groups and around the
county, it filtered into social work as well. So that all the network was there, and . . . so you could use all
that, and use the skills that you gained at Phoenix and at the Ley, to do that. So, it’s had a massive impact
on the way I operated. (JB, CF1162: p. 9)

But, the other thing that I took away from the Phoenix really was the fact that psychiatric illness is not . . .
an isolated thing. It rubs off on the members of the family, obviously, and on other people . . . and you have
to see it in that context. And after being in the Phoenix, if you went to see a patient and you didn’t see the
family or the wife, or – it was like going to examine somebody who’d got a chest problem and having
forgotten your stethoscope. . . . I very much got to work with the people, with the relatives, and so on, and
I took that away from the Phoenix. (JR, CF1162: p. 12)

Rex Haigh, who was subsequently to have a significant role as founder of the Royal College of
Psychiatrists Quality Network for Therapeutic Communities, described in a written contribution
how he first encountered the Phoenix Unit as a medical student:

After my initial culture shock of joining a therapeutic community, I went on to thoroughly enjoy it. I found
something completely different about the way people were with each other – I learnt my psychiatry the
same as other students who were on traditional wards, but I also got an inkling of something that is very
hard to define or put in words. It was something about being allowed to be yourself, about playfulness, and
creativity. I call it the ‘quality of relationships’ – but that’s just words – you can only really feel it – almost
smell it – and I think I’ll be searching for it, like a Victorian Lepidopterist with a big net, for the rest of my
career! (Haigh, 1995; PHOENIX/3)

Working on the Phoenix Unit was not a matter of matching accounts in medical textbooks to peo-
ple’s lives, or learning how to link decision-making to the best available evidence. Staff members
were not implementing theories or following protocols. Rather they were picking up practical
skills. They were gaining judgement and discernment and a style of interaction. There was a way
of being on the Phoenix that was personally transformative as well as therapeutically innovative.
This all has a rather ineffable quality. It may be described in words, but the linguistic expression is
partial and secondary to pragmatic, lived experience. It was perhaps more akin to conversion to a
new world view than a formal acquisition of written knowledge. As it became ingrained, staff
members began to carry the culture of the Phoenix Unit, taking it with them as they moved away.

**Impact on innovation in the local community**

The final section of this paper outlines the development and function of a number of independent
innovative services, to which we refer collectively as ‘therapeutic environments’ (not all are free-
standing organisations); those which had clear historical links with the approach to psychiatric
management developed by Mandelbrote.
Soon after his arrival in Oxford, Mandelbrote encouraged the formation of an active League of Friends. The League’s charitable status enabled the creation of a system of group homes and hostels. Nursing staff were deployed flexibly in community support roles. Originally known as the Oxford Group Homes Organisation, subsequently expanded and incorporated as a separate charitable company under the name ‘Response’, the organisation facilitated the resettlement in the community of many long-stay patients. The group homes were initially ordinary rented residential houses, and residents were chosen according to their abilities and capacity to support and relate successfully with one another. These developments were linked to the establishment of a formal community psychiatric nursing service which was among the earliest in the country. The article in this issue by Hall (2023) gives fuller details of these and related projects.

The Isis Centre began in 1970 as an easily accessible, non-referral walk-in counselling service in a busy retail area in Oxford (Agulnik, Holroyd and Mandelbrote, 1976; Oldfield, 1983). As described in greater detail in another article in this issue (Armstrong and Agulnik, 2023), Mandelbrote’s early work in Gloucester and Oxford had come to the notice of Leonard Elmhirst, founder of Dartington Hall and the eponymous school, college and glassworks. The Dartington Hall Trust, in conjunction with the University of Oxford, was financing a new building in central Oxford to accommodate faculties for the academic study of agriculture under one roof. Elmhirst had offered Mandelbrote street-level space in the building to pursue a venture in community mental health. The offer was accepted, and in 1970, following wide local consultation with community agencies, a unique NHS self-referral, walk-in counselling service was established. The Centre went on to provide academic and clinical training in counselling and psychotherapy, and to spearhead the development of both counselling in primary care throughout Oxfordshire and a counselling service for staff of Thames Valley Police.

Another example was the establishment in 1973 of the Ley Community, a residential facility for the rehabilitation of people with severe drug and alcohol problems. In 1970 the Oxford Regional Health Authority had opened the Ley Clinic, a 33-bedded regional facility for treating drug and alcohol misuse at Littlemore Hospital. Mandelbrote had consultant responsibility for the drug-dependency component with one-third of the beds. A ‘democratic’ therapeutic community model of treatment was initially adopted along the same lines as the Phoenix Unit. This failed to prevent continued misuse of drugs, and the more structured ‘concept based’ therapeutic community model was instituted, stemming from Synanon in California and Phoenix House in New York.3 This model did not fit well in a hospital setting and again, using the structure of a charitable organisation, the service gradually moved to a community setting, renaming itself the Ley Community. Its happenstential origins and early development have been described by Agulnik and Wilson (2007) and are further elaborated in a companion article by Armstrong and Agulnik (2023). Mandelbrote’s own reflections on the Ley Community are available in the oral history recorded following his retirement (Mandelbrote, interview, 1996, TC Voices/168).

A key element in Mandelbrote’s approach to psychiatry was the encouragement and support of settings which could be termed ‘therapeutic environments’. Core elements of this can be discerned in the creation of Restore (an acronym for Rehabilitation Services Trust for Oxfordshire Re-employment), an independent voluntary sector organisation with charitable status. Its serendipitous origins arose from Mandelbrote’s continuing communication with Ernest Gruenberg, described in an article in this issue (Leach, Agulnik and Armstrong, 2023). Restore initially made use of unused hospital buildings and land at Littlemore Hospital, but moved in stages to be entirely based in the community and to provide a range of recovery workshop settings as well as employment advice and training in Oxfordshire. Restore, like Response and Elmore Support Services (see below), remains a crucial element in the multi-agency network of community
mental health resources established in 2015 under the name of the Oxfordshire Mental Health Partnership.

A flavour of the therapeutic community approach could be seen in all the above examples. With respect to staff organisation within the hospital, all ward areas emphasised open communication within a flattened staff hierarchy involving all members of the staff team. Personal initiative in exploring new ideas was encouraged, and this included outreach into the community, particularly in the service of continuity of care. This led to closer communication with agencies and services in the community, which in their turn required easy access to the type of specialist knowledge and support the hospital could provide. More specifically it resulted in key staff in different organisations relating, often informally, across organisational boundaries. Thus the open style of working adopted within the A Division lent itself naturally to informal networking and exploring entrepreneurial opportunities in the local community.

Contemporaneous with the developments described above was the development in central Oxford of a number of hostels for the homeless, set up by charitable organisations including The Church Army, the Simon Community and The Cyrenians. These offered short- to medium-term accommodation to a very vulnerable group of individuals, a high proportion of whom had significant mental health difficulties (Marshall, 1989). A night shelter was also provided by a charitable organisation, which was later to link up with a Portakabin-housed clinic initiated by a small number of dedicated local GPs. What is now The Luther Street Medical Centre evolved substantially over the years. It provided a setting where patients could receive psychiatric assessment and treatment and where psychiatrists in training attached to the A Division obtained first-hand experience of the complex needs of the homeless (Forman, 1992).

Within the criminal justice system, a forward-looking chief probation officer had recruited a talented team of senior officers who established bail and probation hostels and a day centre. Residential provision for prison after-care was made by a local charity formed by and named after Robert Elmore, an Oxford academic. The chairs of the adult and juvenile magistrates’ courts sat on the probation committee and also on the Elmore board. These settings provided conduits through which professionals and decision-makers could readily and informally explore developing ideas. Equally important was the creation of an informal network in which frontline workers from various statutory and voluntary agencies met to discuss potential solutions for those regarded as psychologically and socially vulnerable. These workers included, where relevant, staff from Littlemore.

Paradoxically, the overall widening of provision only served to highlight the needs of a population of so-called ‘difficult to place’ people, whose needs are towards the margins of agency-based provision across the health care, social care, accommodation and criminal justice systems. Their problems are multiple, chronic and complex. This group of people (who were often frequent offenders) presented particular problems for the courts, which could have difficulty in making appropriate sentencing decisions. Such people were not well served by services, their complex needs making them problematic for any one agency or institution. In order to develop possible solutions, the Elmore Committee set up a small multi-professional steering group in which magistrates, probation services, the mental health services and others with first-hand knowledge of the problem were represented. Jon Vagg, a criminologist, was commissioned to assess the nature and size of the problem and suggest solutions. An initial report to the Elmore Committee estimated that 138 individuals in Oxford came into the category of ‘difficult to place’ (Vagg, 1987). A subsequent publication provided a further analysis of the factors underpinning his findings (Vagg, 1992).

In the event, Vagg’s proposals for a solution to these problems – an inter-agency panel and a hostel – although accepted in principle, were not funded. Instead happenstance again intervened and a successful application was made for unspent central government monies. A small
multi-disciplinary team was recruited in 1989 to become the Elmore Community Support Team; it was composed of community workers with experience of working with the homeless, and professionals including psychiatric nurses and social workers with experience of working within the prevailing network of care. Their task was to work in an integrated fashion with both the person and the agencies concerned until such time as those individuals’ needs could be absorbed into the agencies’ core functions. Typical work would be supporting individuals to integrate within housing and hostel accommodation, making provision for rough sleepers, and being involved in court diversion schemes. Retaining the original vision, the team considerably expanded and diversified, and the organisation was renamed Elmore Community Services.4

The Elmore project can thus be seen as another ‘bottom-up’ innovative service development, showing clear historical links to the philosophy and practice of the therapeutic community approach introduced by Bertram Mandelbrote and subsequently practised more widely within the ‘A Division’.

Discussion

This paper traces the history of how Bertram Mandelbrote introduced innovative practices in the care of people with mental health problems in Oxfordshire. These innovations place him as a pioneer in the practice of social psychiatry and the therapeutic community approach. Practices initiated at Littlemore Hospital led to successive changes and informed the development of other progressive community services, and Mandelbrote’s influence is still apparent more than 30 years after his retirement from the NHS. The therapeutic community approach at this time referred to a wide range of disparate and inchoate approaches. Clark (1965) described it as ‘a way of looking at the life of patients in any psychiatric institution and restructuring their lives’, which he distinguished from the ‘therapeutic community proper’ developed in more specialist settings. The best known example of the latter was that established by Maxwell Jones at the Henderson Hospital, which he described as ‘distinctive among comparable treatment centres in the way the institution’s total resources, both staff and patients, are self-consciously pooled in furthering treatment’ (Jones, 1968: 85).

Both types of therapeutic community are still active in the UK. Most of the ‘therapeutic communities proper’ are part of the ‘Community of Communities’ programme at the Royal College of Psychiatrists, which offers them optional accreditation. Its spin-off programme called ‘Enabling Environments’ recognises and supports therapeutic environments like those described above that use a therapeutic community approach. Recent papers have drawn the connection between the twenty-first-century concept of a psychologically informed environment (PIE) and the historical development of the therapeutic community approach (Haigh et al., 2012).

We are also interested here in the nature of leadership and the process of understanding innovative institutional change where that change gradually evolves. Mandelbrote was not attempting to disseminate therapeutic community concepts or implement an overarching vision of better mental healthcare. He was highly impactful, but our findings present his work as falling some distance from the ideals of evidence-based policy and the impact agenda. By trying to separate our historiography from administrative and bureaucratic conceptions of evidence, ideology and impact, we seek to show how institutional innovation is not always a matter of translating knowledge. In Ingold’s terms, Mandelbrote was a maker, not a designer. For Mandelbrote, the therapeutic community approach emerges as a style of management, a way of facilitating communication between staff and patients that also succeeds across organisational boundaries, creating informal networks of provision rather than a more rigid, bureaucratised system of care. Mandelbrote’s flair lay in his capacity to create rich, nurturing environments, insulated from external pressures, that allowed the
The evolution of local institutional innovations in response to local needs and constraints. In terms of the accompanying paper by Armstrong and Agulnik (2023) discussing regulatory culture and happenstance, the settings described above are ecological niches, facilitating environments that enable sustained institutional growth. The institutions and their cultures that resulted are examples of ‘bottom-up’ initiatives, growing in a setting of striking freedom and openness to new ideas, with minimal application of bureaucratic procedures. As such they represent the kind of adaptive organisational learning that Mosley and colleagues regard as having greater potential than the evidence-based approach (Mosley, Marwell and Ybarra, 2019).

The local context in which these developments took place is relevant. Throughout the period under consideration, the expenditure on mental health by Oxfordshire Social Services was among the lowest in the country. It must be a matter of conjecture, whether this acted as a spur to entrepreneurial activity by those whose practice was shaped more by consideration of social rather than the predominantly biomedical models practised by the B Division and at the Warneford Hospital. It is clear that in the absence of any relevant strategy emerging from elsewhere, the A Division of Littlemore Hospital became in effect the hub of community outreach. It is also an example of how a local regulatory culture impacts on the process of innovation.

The vitality and sincerity of this institutional environment is in itself noteworthy. Bonds of genuine friendship between actors allowed for trust and cooperation that more formal and routinised institutional arrangements inhibit. Informal contacts allowed for nimbleness, a capacity for plans to be rapid and focused, and the resulting institutions to be flexible and manoeuvrable. Individuals who had gained experience working in a setting under Mandelbrote’s management picked up practical skills that they subsequently took to new work settings. This was known locally as ‘carrying the culture’. In the terms used by Overeem and Tholen (2011: 741) in their virtue ethics-based critique of New Public Management, Mandelbrote created the conditions for desirable or virtuous development of individuals. This is far from trivial. As Boulton and colleagues point out, understandings of institutional change can be tied to debates about how to evaluate or otherwise investigate the work of healthcare institutions (Boulton, Sandall and Sevdalis, 2020: 6). Measures of concordance with manuals seem very distant from the vivid personal memories discussed above. Sometimes, not having a plan is itself a kind of plan; perhaps, even, the best kind of plan.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

Notes

1. David Millard died on 13 January 2021, after this article had been written.
2. The grant ‘Reconceptualising Recovery Through Provision For Psychologically Vulnerable Persons In Oxford, 1959–1997: A Case Of Positive Deviance?’ Wellcome Trust-funded research project through the Department of Anthropology, University of Oxford. The PI was Elisabeth Hsu; the RA was Tu Thuy Phan.
3. The contrasting histories and styles of ‘democratic’ and ‘concept based’ therapeutic communities are described by Kennard (1998).
4. A description of the service in 2022, together with background history and evaluation, is available at: www.elmorecommunityservices.org.uk.
References

(a) Unpublished documents, interviews and witness seminars

Oxfordshire Health Archives, Oxfordshire History Centre, Temple Road, Oxford OX4 2HT:
Physician Superintendent’s Report to the Management Committee of the Littlemore Group of Hospitals

Planned Environment Therapy Archive, MB3, Church Lane, Toddington, Gloucestershire, GL54 5DQ:
Haigh R (1995) Written extract from a presentation delivered at the ATC Windsor Conference; ref:
PHOENIX/3.
Witness Seminars (in date order):
Oxford Therapeutic Communities Witness Seminar (at Littlemore), 25 April 2013, Ref: CF0923-0924.
Oxford Project Witness Seminars (at Littlemore; recorded by Craig Fees): 6 February 2014, Ref: CF0996-
0997; 26 March 2014, Ref: CF0998-0999.
Elmore Community Support Team Witness Seminar (at Littlemore; recorded by Craig Fees), 15 January
2015, Ref: CF1049-1050.
Phoenix Unit Reunion Witness Seminar (at PETT Archive), 19 October 2016. Ref: CF1161-1165.

(b) Publications

Communities 28: 11–16.

Agulnik PL, Holroyd P and Mandelbrote BM (1976) The Isis Centre: a counselling service within the National


Armstrong N and Agulnik P (2023) Happenstance and regulatory culture: the evolution of innovative com-
munity mental services in Oxfordshire in the late twentieth century. History of Psychiatry 34(1): mm–nn.

of Medical Psychology 26(3/4): 222–244.


Medical Humanities 41: 379–394.


111: 947–954.


Gruenberg EM and Boudreau FG (1960) Reports on group visits to Great Britain’s community-based, open
Memorial Fund, 5–86.

Gruenberg EM, Turns DM, Segal SP and Solomon M (1972) Social breakdown syndrome: environmental and

the “Enabling Environments” initiative. Housing, Care and Support 15: 34–42.

Hall J (2023) The development of supported mental health accommodation and community psychiatric nurs-

Hall J, et al. (2023) The processes and context of innovation in mental healthcare: Oxfordshire as a case study.

Health Hospitals at Horton Road and Coney Hill. Gloucester: Author.