Practitioner Perspective

Honouring Ivor Browne – a titan of Irish mental health best practice

By Dr Karen Ward

Professor Ivor Browne died earlier this year and, to honour this stalwart of the Irish mental health system, I share with you the full interview of a very special discussion with him for IACP members, part of the Elder Wisdom article I wrote for this journal in 2019

Introduction

Professor William Ivory Browne (Ivor) was born in 1929 and died peacefully at home in Ireland, surrounded by his loving family and friends, on 24 January 2024. Since retiring as Professor Emeritus at University College Dublin and as Chief Psychiatrist of the Eastern Health Board in 1994, he continued his psychotherapeutic practice and published two major volumes: the first an autobiography, *Ivor Browne, Music and Madness* (2008); and the second, a collection of written works entitled *The Writings of Ivor Browne* (2013).

As a young man, Ivor was granted a fellowship at Harvard University where he studied Public and Community Mental Health. He returned to Ireland determined to place the principles of deinstitutionalisation at the forefront of psychiatric practice – an initiative that took the care of psychiatric patients away from large institutions into the community.

Ivor conceived and was director of the Irish Foundation for Human Development, which established the first Community Association in Dublin's Ballyfermot – one of the early large-scale housing developments devoid of facilities. Along with a professional team, he worked with the residents to turn the housing estate into a thriving working-class community. Following the success of this project, the life-changing Inner-City Trust was established in Derry.

A gentleman in the truest sense of the word, Ivor Browne was a game-changer in the field of mental health in Ireland. As a key figure and, indeed at times, a lone radical, his calm demeanour and passionate conviction helped his vision over many years. Ivor's holistic view of what was possible, including the integral role of psychotherapy and counselling, harnessed his drive for a revolutionary sea change in our profession. Here, in his own words, he shares his story with characteristic humility and humour.

Interview

KW: How do you view the Irish mental health system of the past?

IB: In the case of Ireland, we became the laboratory for a colonial experiment with the idea of the asylum as a place of removal and containment. I'm thinking, in particular, of the work of Robert Peel and his asylum-building fervour in the 1830s. In Ireland, an asylum infrastructure was built like no other in the British Empire. In pre-famine Ireland, we had roughly 8 million people; the asylum system was built

to accommodate that population. By the close of the 19th century, that population had been halved. You still had an asylum system that needed filling, and filled it was.

Generally, the asylums of 19th century Ireland were notable for what I would call a sort of institutional promiscuity. Most of those institutions were established with a purpose, a curative focus, along with a regime of practices that corresponded to notions of treatment. However, very quickly the number of citizens sequestered within their walls expanded rapidly ... In Ireland, the asylum came to function as a repository for the perceived social ills of the day. Moral treatment gave way to a form of human warehousing into which many transgressive souls were exiled and rendered invisible.

When I was in Harvard, there was a Sikh psychiatrist in our group. At that time, in the early 1960s, the population of India was about 450 million, for which they had 20,000 mental hospital beds. In the Republic of Ireland at that time, we had a population of around 3 million and we had 20,000 hospital beds. My Sikh colleague assured me that you'd have to have a pretty unique kind of psychiatric disturbance in order to get a hospital bed in India. It's an interesting comparison.

Our basic narrative for psychiatric medicine in the 19th century is the establishment of a dedicated institutional site for treatment which rapidly scales up into that dystopian prospect of the overcrowded lunatic asylum on the outskirts of our towns and cities. In my early career in psychiatry, it was precisely that feature – the overcrowded wards of the mental hospital – which I encountered: some 2,000 in Grangegoraman, a further 2,000 at St Ita's Portrane, and a so-called overspill of several hundred in St Mary's in the Phoenix Park. In a word, containment.

KW: How do you view the Irish mental health system presently?

IB: The word now might be "control". Let's say that in the collective conscience of psychiatric medicine, it was that accumulation of bodies in the 19th century that formed the central motif for psychiatry's disciplinary guilt; we incarcerated without restraint in a fashion that must never be repeated. My sociological colleague, Ciaran Smyth, conducted an ethnographic study of a contemporary psychiatric system. He concluded that if there's a single principle organising post-asylum psychiatry, it would be the rule of permanent mobility. There must be no accumulation of bodies at any juncture, not in the acute ward, not in the day centre, and not at the medium-support hostel. Everybody must keep moving. The result of this new preoccupation with movement is a less visible but quite definite control system that has emerged this time in the space of the community.

Certainly, there was movement within the mental hospital at the level of the ward system, but while there was a road in, there was no obvious road out. It was a one-way system. The present system has produced little nuclei of chronicity. Instead of an occupancy for life in one institution, the contemporary patient occupies a circuit, distributed across a series of interconnected, certainly smaller institutional sites where they must be seen to be moving. However, this is not a situation where the person becomes a genuine part of the community. It seems more like the insertion of a set of navigable but closed institutional channels. So, it's no longer confinement that psychiatry must defend itself against; these days it stands accused instead of neglect, as we encounter the figure of the abandoned mad person on the streets of our cities.

I think that effect can be seen most clearly in the case of Italy. In Franko Basaglia's work in Trieste in the 1960s, he prepared the ground for deinstitutionalisation through the creation of coherent community-based alternatives to hospital life: day centres, cooperative enterprises, and so forth. He created a community-based infrastructure that could serve as an alternative to the mental hospital. But in Italy, as you went further south, you encountered what was called the *abandonate,* essentially former mental patients left to their own devices in the cities and the towns without recourse to any kind of infrastructure. That process was repeated in California. Before his presidency, when Reagan was Governor there, he seized on that idea of a radical, sharp closure of the mental hospitals. People were put out on the street with no support structures whatsoever.

I mention Reagan deliberately here since we now live in the age of neoliberalism, which gives full expression to Reagan and Thatcher's idea of a market-driven, atomised society that is more or less hostile to any notion of community, let alone a therapeutic one. If I have one major criticism of deinstitutionalisation it would be that, as a reform movement, we liberated former inmates of the mental hospitals into an increasingly hostile society where the very idea of community was under assault.

KW: What are your dreams for the future of mental health in Ireland?

IB: My first hope for the future is for a far greater emphasis on psychotherapy. I would like to see the reintroduction of training in psychotherapy for psychiatrists. It used to be the case in 20th century America, and to some extent in France, that training in psychotherapy was a basic

element of the formation of the psychiatrist. I do think that kind of approach would be invaluable. These days a consultation in outpatients [hospital department] can be a very brief encounter. A basic knowledge of psychotherapy will tell you pretty quickly that there are very few human problems of living that can be solved within the confines of the five-minute medical consultancy interview. Certainly, it can accommodate the liberal use of medication, which is of course a pseudo-solution that can often make the problem worse.

I also hope that the field of mental medicine can rediscover the connection between human problems of living and life itself. We are not structurally decoupled monads operating outside the flux of life and its changes of circumstance, unexpected tragedies, disappointments, and joys. Our symptoms arise out of these life experiences; they are signs of our own attempts to make sense, to find solutions, however inadequate, to the vicissitudes of life.

I would also love to see mental health services re-imagined according to the original notion of asylum, the idea of a safe harbor. All of us at certain times in our lives find ourselves in a state of overwhelm in our own praxis of living. Some of us will need certain forms of understanding and support that friends and family cannot give. At such times the mental health system should not become an end destination. It should be a sanctuary, a temporary place of refuge that gets you back into the game of life. That kind of approach will only work when mental distress is incorporated and understood as an integral part of life, rather than some form of disease. I would argue for the recognition of *dis-ease*, in the sense of being in a state of unease, as opposed to disease, in the sense of an objectified form of illness.

KW: What do you see as your contribution to Irish mental health in the principle that "one person can make a difference"?

IB: Mine was an attempted contribution. Certainly, I participated in a reform movement that saw a radical reduction in the patient populations of mental hospitals. In short, I found myself in the right time and place, you might say belatedly in the case of Ireland, to fully take on and support the process of deinstitutionalisation which had already found its institutional logic and momentum in Europe and America.

At a more philosophical level, I did encounter a certain way of thinking in psychiatric medicine, which you might call mechanistic: the idea of the patient as broken in some way that required fixing. In my own approach, I have taken the view that we are all living systems trying to make sense of the world and, as such, are in need, at certain crucial times, of some kindness, compassion, and understanding in order to find our way back to health. Despite the various kinds of opprobrium, it got me into along the way, I've tried to proceed according to that basic principle – that we are all living, human "becomings", trying our best to make sense of life as we think we know it.

Conclusion

For many years, my psychotherapy practice was close to Grangegorman, previously one of the biggest Irish psychiatric hospitals – a place of incarceration (now a university campus). As a child, I remembered a taunt heard by many a Dubliner "If you don't … I'll go mad and be locked up in Grangegorman!" I reflect on how, in my lifetime, Ivor Browne almost single-handedly changed how people with mental health issues are treated. His ground-breaking approach removed stigma by acknowledging the fact that most of us will, at some stage of life, need help in dealing with the mental and emotional impact of the vicissitudes of life. I have been honoured, in my working life, to be a small part of the evolution of his dream, especially in this inner-city locality of Dublin.

I think we can safely say that the legacy of Professor Ivor Browne has made a huge significance in the past, it certainly contributes to the present, and with our psychotherapeutic and counselling profession forging ahead, it will hopefully do so long into the future.

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