CHAPTER 19

CHANGING MINDS

STEPHEN GARTON

IN 1939 MOST PATIENTS undergoing psychiatric treatment were inmates of state-run mental hospitals. Three in every one thousand Australians resided in these hospitals, 60 per cent of them compulsorily detained by court orders. By the 1980s the structure of mental health care services had changed greatly, and so had the nature of the population under treatment. Estimates of the proportion of the population suffering psychiatric disorders now ranged as high as 25 per cent, and psychiatric patients occupied 40 per cent of all public hospital beds.

More and more of those receiving psychiatric help were treated outside mental hospitals. Outpatient facilities expanded, and private clinics were opened. By the 1970s more than 300 psychiatrists were at work in private practice. There was a growing number of community contact centres where people could receive help from psychiatrists, psychologists and social workers without being admitted to hospital. Mental hospitals discharged many patients to alternative forms of residential care: hostels, boarding houses and nursing homes. Of those who remained in hospitals over half were now voluntary patients. All in all the system of psychiatric treatment in the 1980s was significantly different from the one that existed 40 years earlier. Why?

The shift from asylum to community-based services was a response to a longstanding crisis in Australian mental hospitals. Since the turn of the century increasing rates of admission had outstripped the growth in available hospital beds. Patients were forced to sleep on mattresses on the floor or in temporary beds in dining rooms. World War II made matters even worse. When some mental hospitals were transferred to the armed services for the treatment of soldiers, civilian patients had to be moved to institutions already packed. By 1949 there were nearly 3000 more patients than proper beds in Australian mental hospitals, much of the accommodation was ramshackle and antiquated, and there were too few doctors and nurses.

Psychiatrists and hospital administrators had already resorted to drastic measures. The most common policy was to give some patients more attention than others.

Doctors believed that there were two basic populations of patients. The first had acute and curable conditions, and these were treated in well-staffed hospital clinics and admission wards. The second were incurable, including chronic schizophrenics, senile dementia sufferers and the mentally retarded; they were accommodated in poorly staffed and maintained wards—'back wards'—and hospitals. During the 1940s responsibility for treatment of chronic patients was transferred from psychiatrists to local doctors who inspected them monthly. They were kept docile by a variety of custodial devices: the daily 'bromide cocktail'; aperient mixtures, which may have guaranteed regularity, but incapacitated the victim; and the straitjacket. At the turn of the century these means of control had been rarely used in Australian mental hospitals. By the 1940s they were common: unhappy resorts for doctors who wanted to extend their medical expertise, not to be mere keepers.

Problems in the hospital system became public knowledge. In 1948 the Sydney *Sun* published a series of articles criticising conditions in Callan Park, the city's principal mental hospital, based on the experiences of a reporter who got a job there. The paper alleged that buildings, food, clothing and bedding were inadequate and that staff neglected their duties and ill-treated patients. An official inquiry cleared the hospital staff of charges of cruelty and neglect but concluded that conditions were unsatisfactory. Headlines nevertheless spoke of 'Mental patients being treated like convicts and animals' and described mental hospitals as 'Concentration camps'.

An investigation into Victorian mental hospitals in 1950 also reached adverse conclusions. The Kennedy inquiry severely criticised the administrative work of the Mental Hygiene Department and especially of its director, who was found to have frustrated efforts at reform. The report also denounced conditions in hospitals, noting especially the high level of physical restraint and the poor training of nursing and medical staff.

Criticism became still more intense after 1950, some of it from within the medical profession. In 1953 the *Medical journal of Australia* described the overcrowding in mental hospitals, above all in New South Wales, as 'a chronic festering sore'. In 1955 the federal government set up an inquiry into mental health facilities throughout Australia, headed by Dr Alan Stoller, a medical officer in the Victorian Department of Mental Hygiene. Although the Stoller report welcomed such innovations as a unique research unit in Brisbane and some advanced early-treatment clinics in Victoria, its overall conclusion was of 'mass overcrowding, with a general level of custodial care with little active treatment'. The report concluded that all the states were, by the best world standards, backward in their treatment of mental illness. The worst was New South Wales, which lagged behind because for many years its system had been starved.

The Stoller report had an immediate impact. Increases in commonwealth funding enabled state governments to improve facilities and engage in essential repairs. Tasmania and Victoria did most to improve hospital facilities—New South Wales still lagged: a royal commission which in 1961 examined Callan Park found that problems analysed in the Stoller report had not been overcome.

In the 1950s some psychiatrists argued more forcefully than their predecessors that problems in the mental hospital system were not simply a consequence of inadequate funding. They were influenced in particular by studies in Britain and the USA which suggested that the traditional mental hospital created the 'institutionalised' patient—perfectly adapted to the peculiar environment of the hospital but incapable of surviving outside. The mental hospital, it was argued, was closer to a prison than a hospital for treatment and rehabilitation. As Cunningham Dax put it in 1955, 'the relationship with the penal system had never been broken'.

Reformers proposed two solutions. The first was to create a 'therapeutic community' within the hospital which would express changed social relations. Cunningham Dax argued for a 'bold reorganisation of the hospital system', by abandoning custodial practices, removing authoritarianism and encouraging patients to lead independent lives. This required retraining of staff to ensure that hospital life became genuinely rehabilitative. Dr Denis Barker and his colleagues at the South Australian Receiving House argued that the hospital environment had to be moulded into a therapeutic instrument: hospitals needed to adopt an open-door policy, foster outside involvement in hospital life, and encourage patients to leave; narrowing the gap between hospital and community would ease the transition of the patient back into the wider society.

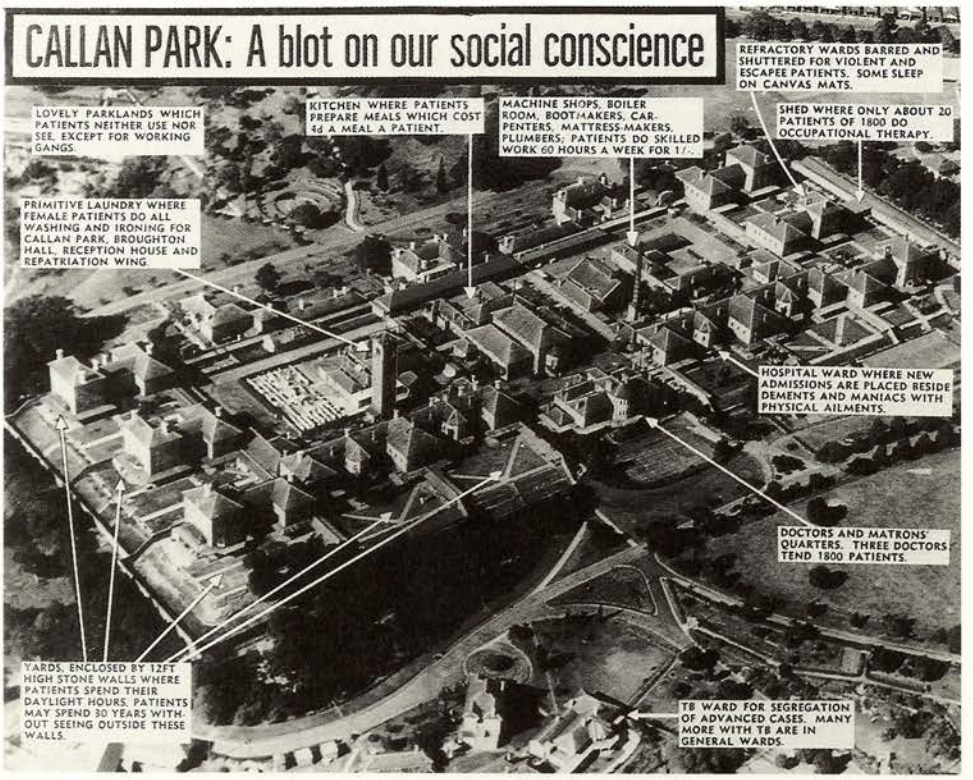
The second solution, 'community treatment', was an extension of this approach. Regional networks would be set up consisting of outpatient facilities at general hospitals, day clinics, early treatment clinics, family casework agencies and child guidance centres. In these facilities, psychiatrists, whose job was to diagnose and treat the patient from a total biological, social and psychological perspective, would co-ordinate the efforts of psychologists, who helped in the treatment of patients' mental and social problems, and social workers, who eased patients' transition into the community. Psychiatrists believed that if community treatment was adopted fewer people would have to go to hospital. Patients who had been afraid of going to hospital and embarrassed by its stigma would now seek help in the early stages of their illness when they were more curable. Regional services would make it easier for discharged hospital patients to remain in the community.

In the 1960s enthusiasts for community treatment began to search for a more precise understanding of the role of poverty and social disadvantage in mental illness. Thus developed a 'social psychiatry' movement, whose advocates argued that community treatment centres should be concentrated in areas where the social groups most in need of care, such as the overlapping categories of migrants, the poor and housewives, could best be served. In addition, treatment teams of psychiatrists, psychologists and social workers should combine their skills in order to assess the social circumstances of the individual and tailor therapy and rehabilitation to the needs of patients, friends and relatives.

From 1939 new treatments for mental illness, the shock and coma therapies, developed in Vienna and Rome, were introduced into Australian mental hospitals. Shock therapy had first been tried in the 1920s with the use of malaria-induced fits. In the 1930s shocks were induced by the drug cardiazol and in the 1940s by electroconvulsive therapy (ECT). For coma therapies, insulin and various narcotics were used. Advocates of these therapies made strong claims for their effectiveness: Melbourne psychiatrists R.S. Ellery and D.C. Lear claimed improvement rates of nearly 90 per cent in cardiazol experiments.

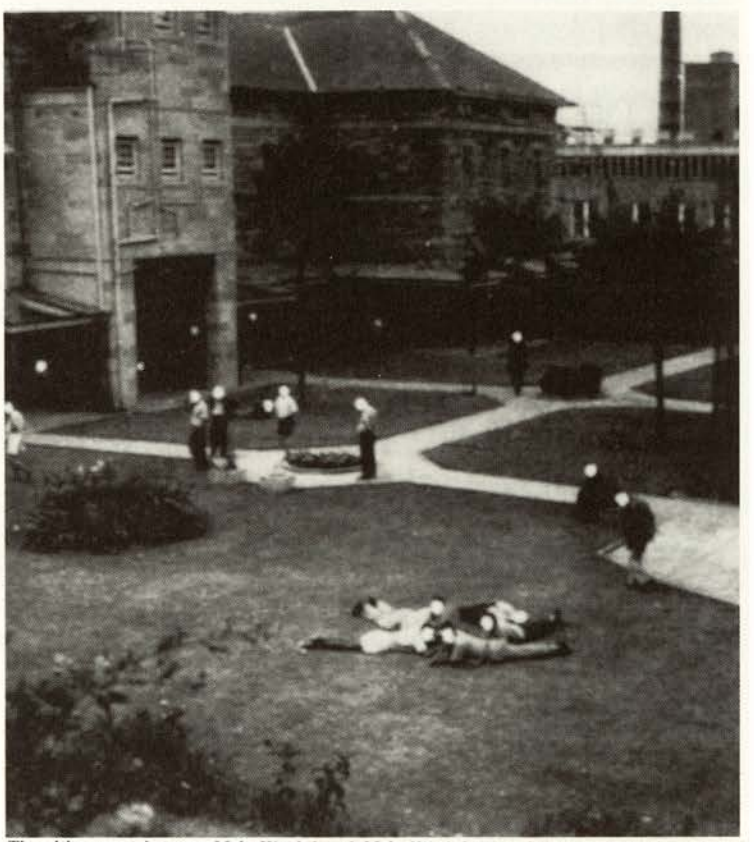
Alan Stoller and others concluded, however, that rigorous trials had not confirmed early results. More disturbing were reports that there was a euphemistically entitled 'three per cent irreversible coma rate' and that as many as 25 per cent of patients undergoing shock therapy suffered spinal injuries or had coronary problems. From the lay point of view, these methods were often frightening.

Doubts about shock and coma therapies helped to create a sympathetic climate in the 1950s for new treatments by surgery and by tranquillisers and other drugs. Psychotropic drugs—those that affected mental activity—enabled the most important breakthrough in psychiatry. They caused a demonstrable decline in the severe symptoms of schizophrenia and other mental illnesses. Some of these treatments, however, were hazardous. It was not until the 1960s that the long-term side effects of psychotropic drugs became known. Early forms of brain surgery



Right.
The Sunday Sun, *1 July 1948, gives readers a bird's eye view of the asylum in Rozelle, Sydney, and detailed advice on how to interpret the world behind its walls. 'Dements' and 'maniacs' are among the words reformers try to erase.*

Captioned photographs used as evidence in the royal commission of 1961 into Callan Park Hospital.



The airing court between Male Ward 1 and Male Ward 2 may give some indication of the apathetic disinterest of patients who have nothing to do

Opposite.
A doctor fits electrodes to the head of a patient at Callan Park in 1976. Photograph by John O'Gready.
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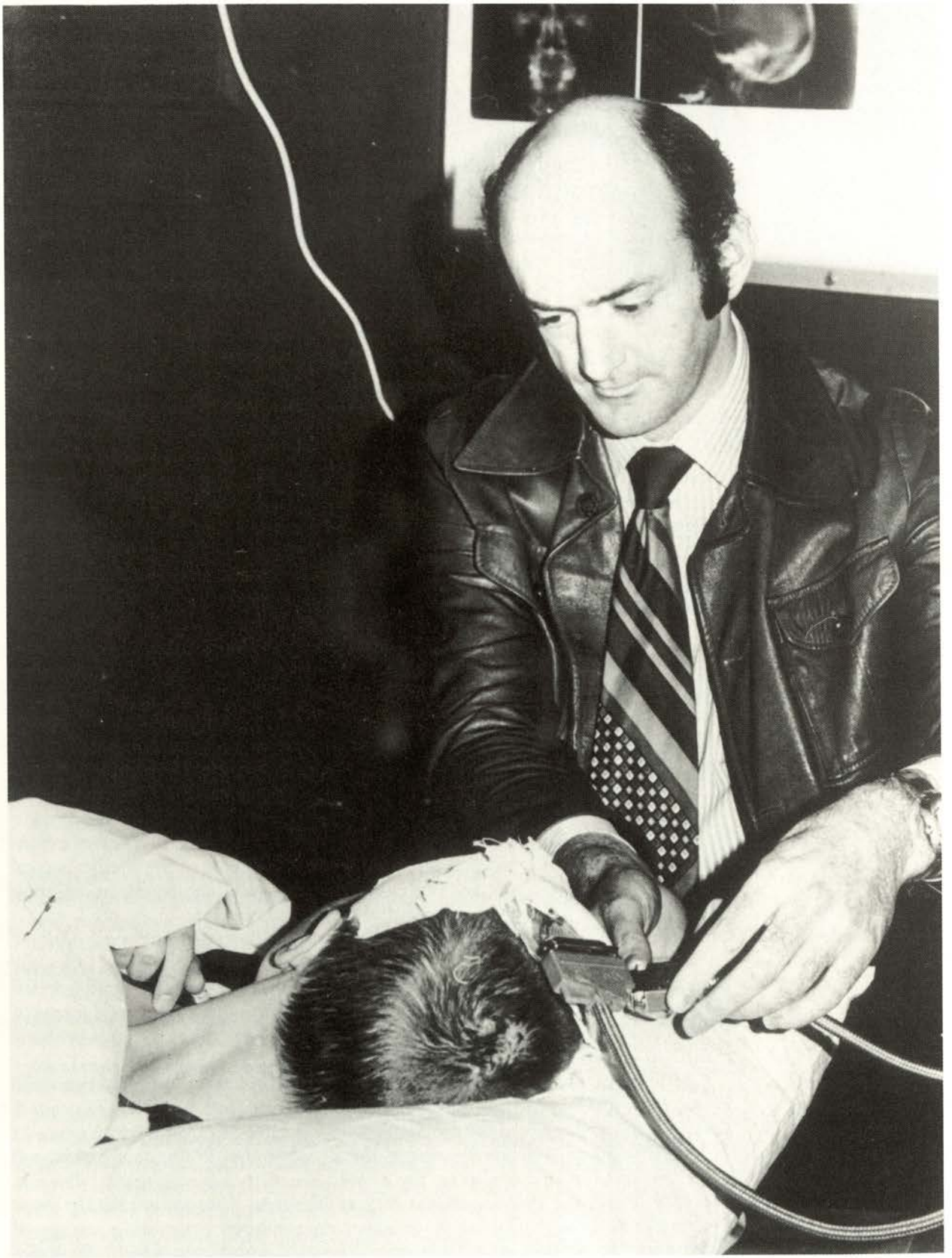

caused even more serious problems. They resulted, for example, in epilepsy for as many as 10 per cent of patients.

But psychiatrists were now confident that the new drugs would make it easier to discharge many patients from mental hospitals, and would reduce the length of stay in hospital for first admissions. A.T. Edwards, a Sydney private psychiatrist and ex-superintendent of Callan Park, believed that these treatments emancipated psychiatry, by giving it a set of resources to compare with those used in general medical practice.

The campaign for psychiatric reform included a more determined effort by psychiatrists to raise community awareness of mental health problems. Convinced that mental illness was more widespread than commonly thought, they were anxious to make the community aware of new methods of treatment and to remove fears aroused by the old. Otherwise, they warned, the social problems caused by mental illness might reach epidemic proportions.

In 1945 the *Medical journal of Australia* declared:

> one of the most striking features of medicine in recent years has been the intrusion of psychiatry into almost every type of practice.

World War II and the policy of postwar reconstruction provided favourable conditions for psychiatrists to argue that mental illness was a significant and increasing problem. Experience from World War I suggested that returned soldiers suffering psychiatric disorders would present a serious public health problem. Such expectations of the war's effects converged with the theory that mental illness was far more prevalent than had been recognised. The psychiatrists of the 1940s argued that it was not just the 'socially maladjusted' who suffered from mental problems, but a broader range of people who would not previously have been considered mentally ill. Underpinning this argument were assumptions derived from socialism and Freudianism. Psychiatrists such as R.S. Ellery and Alan Stoller believed that modern industrial society bred mental strains leading to an increased incidence of illness. Ellery came to believe that capitalism caused mental illness and to hope that socialism would cure it. Stoller and most of his colleagues stopped well short of that conclusion. Freud suggested to psychiatrists that mental conflicts lay behind many forms of social behaviour. The meeting ground for psychiatrists of diverse ideological persuasions was preventive medicine. The term 'psychosomatic' became common. Doctors said that many patients reporting to general practitioners had mental, not physical problems. It became a part of preventive mental health schemes to educate general practitioners in psychiatric problems, enlisting them as agents in the early recognition of mental illness.

The concept of psychosomatic illness was closely allied to another new concept. Some psychiatrists argued that many forms of social behaviour were really the product of 'mass neurosis'. The *Medical journal of Australia* even declared that psychiatry could cure absenteeism. Psychiatrists sought to redefine many forms of behaviour as mental in origin with the aim of extending the scope of psychiatric treatment in the interests of 'social well-being'.

The ideas of psychiatrists were spread by films and the press. American and British films produced in the 1940s such as *Now voyager*, *Lady in the dark*, *The seventh veil* and *Spellbound* depicted the problems of people suffering from various neuroses and psychotherapy effectively curing them. Since the 1920s newspapers and magazines had featured articles on the importance of recognising mental illness in everyday life. In the 1950s headlines such as 'Neuroses rules today's family' were common and were reinforced by an advertising industry promoting a range of treatments for depression and anxiety. Women's periodicals were a favourite

The Women's weekly *encourages readers to diagnose their own emotional ups and downs.* Australian women's weekly, *22 June 1955.*

For 'today's tension troubles', a 'daily thought: "Aspro" with a cup of tea'. Australian women's weekly, *24 Oct 1954.*

vehicle for this literature. In the *Australian women's weekly* stories like 'Everyone suffers from fits of depression' and 'Physical symptoms may have an emotional cause' prompted readers to wonder if they were suffering from mental problems requiring psychiatric treatment. Pharmaceutical companies extensively advertised drugs for the relief of mental problems.

The spread of these ideas affected the practice of psychiatric treatment. Doctors found that more patients began to demand certain types of treatment, particularly psychotherapy. There was an increase in the number of people, especially women, seeking admission to hospitals and clinics as voluntary patients.

As psychiatry came to be seen as more effective, and as mental illness came to be thought of as more widespread and 'normal', social reformers and people in charitable organisations displayed a revived interest in the problems of the mentally ill. Although philanthropic concern with psychiatric patients had developed early with the establishment of an After Care Association in 1906, the sentiment waned. In the 1950s concern revived, and psychiatric reform groups, after-care associations, patient support organisations and mental health associations were established in all states. They raised money to improve hospital facilities, organised outings for patients and established hostels, recreation centres and sheltered workshops for discharged patients.

Politicians also advocated psychiatric reform. In response to the 1949 inquiry into conditions at Callan Park, the Liberal member for Ryde in the state parliament, Eric Hearnshaw, argued that 'the work of rehabilitating damaged personalities is just as important as any economic activity'. In the federal parliament, Labor senator for Western Australia, Richard Nash, unsuccessfully attempted in 1950 to guarantee psychiatric patients a government pension. He declared that the hospital environment for most mental patients gave them 'no chance of being rehabilitated'. After long neglect, such sentiments provided the basis for legislative reform. In 1958 Victoria and New South Wales enacted legislation, followed by Queensland and Western Australia in 1962 and Tasmania in 1963. The notion of the certified patient was replaced by that of the temporary patient who underwent a six-month trial period before either being released or being classified as a continuing-

treatment patient. Other concepts and institutions were also redefined. Mental hospitals became hospitals, reception houses became admission centres, and deliberations about the best treatment for the patient were conducted increasingly within informal tribunals rather than in formal trial proceedings. The old language of custodialism was being replaced by a new medical terminology.

Changes in the form of care tended to produce a different population of patients. While the themes of loneliness, isolation, marital conflict, domestic violence, unemployment and stress recurred in the lives of patients, the shift from a hospital to a community-based system expanded the range of people who received some form of psychiatric treatment.

In the 1940s and 1950s most patients were miners, labourers, factory workers, the wives of such men, and domestic servants. A further group came from the skilled working and tradesmen groups, with such occupations as carpenters and commercial travellers. Women were in the majority, most of them married; most of the men were single. Men were commonly diagnosed as schizophrenics or alcoholics; women were more usually termed depressive. Most patients were middle aged, and at least one-fifth of inmates were aged over 60 (compared with one in eight over 60 in the general population).

Senior psychiatrist in the New South Wales School Medical Service, Dr W. Wyatt, explains to teachers in 1968 the bases of mental health.
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To these people a new group was added in the 1950s. Psychiatrists noted that an increasing number of migrants, particularly from eastern Europe, had distinctive problems. Many newcomers with skills were forced to work in menial jobs and cope with different customs, alienation, isolation and language barriers. Some suffered mental breakdown.

After 1960 the growth in the numbers of private psychiatric practitioners and outpatient facilities yielded an increasing proportion of patients from higher socioeconomic groups. Most people receiving outpatient and private care were women, usually married. And now many women sought help from general practitioners. They were commonly diagnosed as suffering 'suburban neurosis' and depression and often remained at home with the aid of prescribed tranquillisers.

The appearance of private clinics, outpatient, hostel and boarding house facilities changed the composition of the mental hospital population. By the 1970s the discharge of geriatrics to nursing homes made hospital inmates generally younger, aged on average in their thirties and forties. And with more women seeking outpatient care, most hospital patients were now men, usually diagnosed as chronic schizophrenics or alcoholics.

A person could be admitted to psychiatric treatment by various routes. Some people sought treatment simply because they believed they were sick. More often the decision was made by others. Sometimes police acted to put people into psychiatric care. In other cases families or friends encouraged or forced people to seek treatment. Family doctors also referred patients to psychiatrists.

It was usually males who were apprehended by police and brought before a magistrate for committal. Commonly the reason was drunk and disorderly behaviour, disturbed behaviour in a public place or attempted suicide. Drunks who ran naked in the streets, smashed windows or could not be calmed were the subjects of lunacy charges. What distinguished such people from those charged with criminal offences were signs such as delusions of grandeur or fears that people were following them, or that they were being influenced by outside forces. Police were also called to the scene of disturbances by relatives, neighbours or employers. Domestic violence which erupted on to the street sometimes led neighbours to report these incidents to the police. Repeated reports could lead to a lunacy charge. Occasionally employers acted. The manager of one firm called the police after an employee made noises in the office and shouted 'hurrah' in the boardroom.

People influenced by families to seek psychiatric treatment were a varied group. A significant proportion were the mentally handicapped and elderly sufferers of dementia, people whose incontinence or other troublesome disability had become too heavy a burden for relatives to endure. It was easy to arrange for the admission of retarded or aged relatives.

Some families coerced relatives into psychiatric care. Vivian B. was taken from Queensland by her family and admitted to a Sydney clinic because she cried continuously and declared her intention of becoming a Catholic. Her family had her admitted against her will by arranging for two local doctors to certify that she was mentally ill. In other cases family breakdown occasioned the search for a psychiatric solution. Patrick was a married schoolteacher, working long hours at extra jobs to pay off a house. The sudden return of his brother, whom he had not seen for a number of years, precipitated a fit of anxiety. He felt incapable of working, lay round the house for long periods and dosed himself with tranquilisers. Eventually the breakup of his marriage forced him to seek psychiatric help.

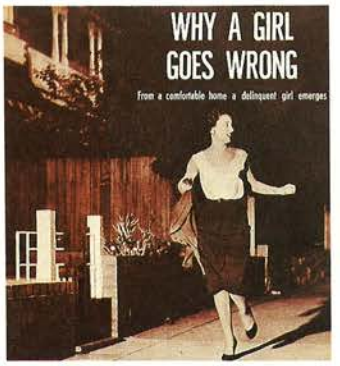
Often the local family doctor referred patients, especially women, for psychiatric treatment. Women who suffered depression, anxiety and psychosomatic disorders went to doctors with physical complaints that doctors diagnosed as mental in origin. Many were involved in unhappy marital and sexual relations, unsatisfied, with few outside interests, having to cope with the strains of raising a family. Depression led them to fall short of husbands' expectations and increased marital tension. Failure to respond to tranquillisers led to further psychiatric treatment.

Childbirth, desertion, bereavement and other life crises were also occasions for psychiatric intervention. The pressures of poverty, the lack of a breadwinner or the demands of a family were frequent causes of breakdown, especially among women who lacked family support. Eve I. had been the victim of domestic violence before her husband committed suicide. She began to live with her mother and stepfather but found that her stepfather was also violent. She left home and tried to support herself and her young child but struggled to make ends meet and felt unsupported emotionally as well as financially by her family. She became depressed and was admitted to a psychiatric institution.

So there were by 1970 a number of psychiatric patient populations. In addition to the traditional hospital inmates such as senile dementia patients, chronic psychotics and the mentally retarded were patients, outside the hospitals, with less serious neurotic and emotional problems. The latter tended to be people who could afford private clinical treatment. Poorer people were more likely to be defined as psychotics and receive mental hospital care followed by discharge to a hostel, nursing home or boarding house. This diversity was a product of the postwar campaign by psychiatrists to reform the system of psychiatric treatment.

The golden age of psychiatric progress never came. The extension of treatment facilities, construction of new patient populations and growth in the influence of psychiatrists created new problems. As well as easing community prejudice against psychiatric treatment, the reforms, by extending the reach of psychiatry into people's lives, provided new points for popular opposition to psychiatric policies and practices.

Psychiatry came under attack in the late 1960s and 1970s by a number of writers in England and America: R.D. Laing and David Cooper, leading British psychiatrists, Thomas Szasz, Professor of Psychiatry at New York State University, and Erving Goffman, an American sociologist, were prominent opponents of the profession. Through paperback publications they enjoyed a wide audience in Australia as elsewhere. Anti-psychiatrists argued that psychiatry was a form of social control, defining all forms of behaviour that did not obey conventional social rules



'Delinquency' was a popular explanation in the 1950s for much behaviour among young people of which parents and teachers disapprove. Some journalists wrote of delinquency as if it were a clinical disorder with measurable incidence in the population. Here in Pix *for 22 Sept 1956 the life history of a fictional girl, Helen Hughes, is told in a sequence of seventeen captioned photographs, a 'typical' case history, intended to alert parents to early signs of delinquency in their children.* Pix *promoted the efforts of the New South Wales Child Welfare Department and told parents to spend time with their teenage children, to treat them as friends.*
MAGAZINE PROMOTIONS

as diseases requiring psychiatric treatment. They denied that mental illnesses were actual diseases in the same sense as physical illnesses. Psychiatrists, they said, applied an inappropriate medical model to behaviour which stemmed from social oppression and family conflict.

To these arguments were added complaints of medical abuses in the treatment of the insane. In Australia groups such as the Citizens Committee on Human Rights (an offshoot of the Church of Scientology) and the Foundation for the Abolition of Compulsory Treatment and, in New Zealand, the Campaign Against Psychiatric Atrocities, spread the arguments of such overseas organisations as People Not Psychiatry. They criticised psychiatrists for overprescribing drugs, making excessive use of electroconvulsive therapy and employing dangerous forms of psychosurgery. They argued that such treatments were often administered without explaining to the patient or relatives their consequences and long-term side effects.

The feminist and gay movements joined in, arguing that psychiatry was not a neutral therapy but a means of enforcing masculinist and heterosexual behaviour as the only modes socially acceptable and normal; people who failed to meet these standards were defined as ill, and psychiatric treatment was designed to force them to conform. These views were communicated forcefully to Australian psychiatrists at a historic joint conference of the American Psychiatric Association and the Australian and New Zealand College of Psychiatrists in San Francisco in 1969. The gathering was picketed by representatives of the student, gay and women's movements, protesting over the involvement of psychiatrists in what were said to be forms of social control. During the 1970s Australian conferences on 'Women and Madness' and 'Homosexuality' provided forums for the criticism of psychiatry.

Representations of psychiatry in popular media began to reflect these critical views. Books such as *Family life*, *One flew over the cuckoo's nest*, and *I never promised you a rose garden*—each made into a successful film—depicted hospitals as places of imprisonment and staff as custodians eager to keep order in wards at the expense of the patients' well-being. In Australia the novels and poems of Peter Kocan, declared criminally insane after his attempt to assassinate ALP leader Arthur Calwell in 1967, conveyed similar images of the lives of patients in mental hospitals. Newspapers ran headlines such as 'Psychiatrists often misguided', 'Prejudice found in mental hospitals' and 'Surgery often used on psychiatric patients'.

Disquiet with particular psychiatric practices was also expressed by other professional groups. Some lawyers argued that patients at hospital committal proceedings needed legal representation to safeguard their rights. On one estimate over half the patients admitted to mental hospitals suffered personality disorders rather than mental illness; such cases, lawyers said, required regular review to protect them against wrongful confinement. In 1972 the New South Wales Mental Health Act Review Committee, established to examine legal and ethical issues, recommended the introduction of a pilot scheme of legal representation for patients. In 1979 South Australia became the first state to enact procedures for legal representation. This was a scheme supported by Justice Michael Kirby and the Australian Law Reform Commission. Some psychiatrists, such as W.A. Barclay, adviser on mental health to the New South Wales government, doubted that the benefits would outweigh the costs; but legislation similar to South Australia's was passed in New South Wales in 1983 and appeared imminent in other states.

Many psychiatrists reacted against what they perceived as unwarranted attacks. R.W. Medlicott, Emeritus Professor of Psychiatry at the University of Otago argued in the *Australian and New Zealand journal of psychiatry* that *One flew over the cuckoo's nest* was a 'grotesque commentary' and believed that western psychiatrists were being blamed for perversions like those practised in Russia. Others defended

the use of electroconvulsive therapy and argued that popular views were misconceived. David Maddison, in his 1975 presidential address to the Australian and New Zealand College of Psychiatrists, rejected the criticism of those 'who seek simplistic solutions to complex problems' and declared that psychiatry was 'one of the truly liberating forces' in modern society.

The frustration of psychiatrists in the face of widespread criticism was understandable. Far from advocating compulsory confinement, they had criticised hospitalisation and sought alternative treatment facilities. There were other issues, however, on which criticism of psychiatry was more cogent. Some psychiatrists certainly believed that forms of social deviance, such as homosexuality, were diseases requiring treatment. Some patients were labelled deviant with little or no investigation of their social circumstances. In private practice, in clinics or in hospitals, many patients found sympathetic and skilful psychiatrists, psychologists or social workers able to help them through emotional crises. Others were not so fortunate, especially people sent to hospitals where overburdened doctors administered drugs and ECT with little effort to ascertain underlying causes. Controlling symptoms had become the first and last resort of some psychiatrists.

The force of critical opinion was recognised by many psychiatrists, with diverse responses. Some argued that mental illness must be defined more strictly, to ensure that medical treatment was provided only for those with organic illnesses. Psychiatry, they said, was a biological and clinical science, and too many cases of emotional disorders, best left to psychologists and social workers, were being treated by psychiatrists. They believed that the charge that psychiatry was a form of social control resulted from medical involvement with cases that were not properly the preserve of clinical psychiatry. Others disagreed. They insisted that colleagues should be more tolerant of social deviance and more aware of the problems of social values and prejudices in diagnosing and treating their patients. In 1980 R.W. Medlicott was urging that anti-psychiatry critiques be taken seriously. And in an article significantly entitled 'Normality and the psychiatrist', Robert Goldney declared that to be an effective healer the psychiatrist must

Peter Kocan in his flat in 1977. He wrote two novels about life inside asylums where he was a patient. The treatment *and* The cure *were set reading for high school students in New South Wales; their frankness and humour offended some parents.*
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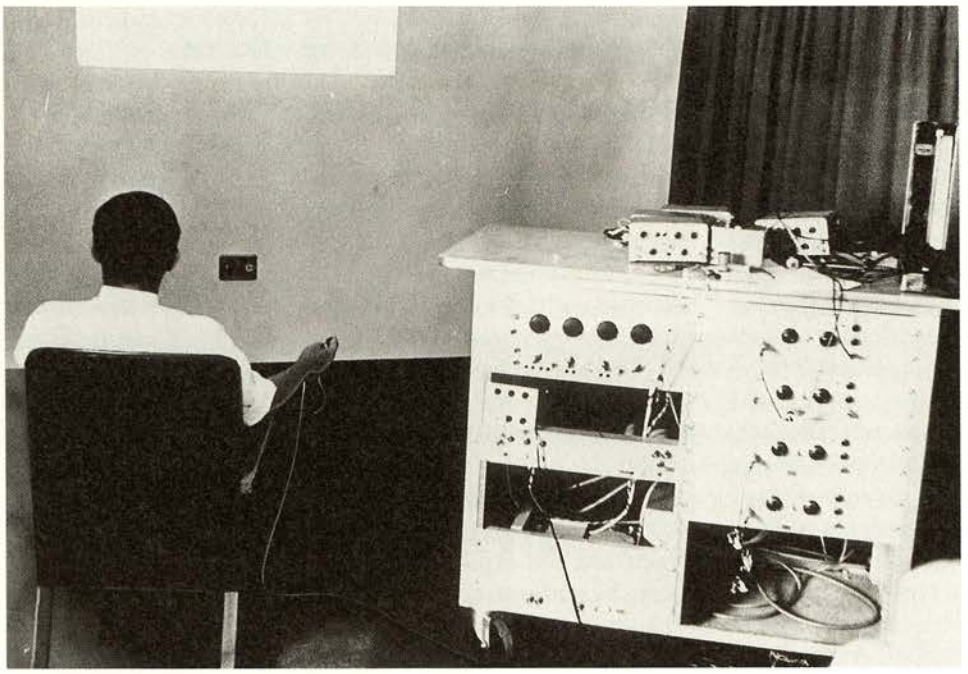

A patient undergoing aversion therapy in 1968. Words are flashed on the small screen as he presses a button. If the words refer to pleasures that he is not meant to enjoy he receives a small electric shock. Some doctors and patients who believed homosexuality to be an illness attempted a 'cure' in this way.
FAIRFAX PHOTO LIBRARY

'become aware of his own socio-cultural outlook'. Some psychiatrists believed that the best way to deal with criticisms of psychiatry and with the initial problems raised by community treatment was to further extend community services. They proposed that nearly all patients be treated outside residential hospitals, in order to do away with the remaining custodial power of psychiatrists.

People professionally concerned with mental health, as well as state government health departments, were firmly committed by the late 1970s to a policy of community care. Governments now gave more money for decentralised and regional psychiatric services to ensure the success of community placement schemes. These services enabled patients to be moved from hospitals into hostels and half-way houses. More psychiatrists, psychologists and social workers were employed to operate these services. Research suggested that patients treated outside mental hospitals had the best prospects for rehabilitation. Patients and relatives were said to favour community care, as psychiatrists had hoped, because it did not stigmatise them as hospitalisation would.

Mental hospitals were now used more and more as short-term crisis centres: admissions steadily increased, but the number of resident patients declined sharply. Between 1965 and 1978 the median length of stay fell from 29 to fifteen days. Other trends, however, were disturbing. An increasing proportion of patients, from 15 per cent in the 1940s to 60 per cent in the 1970s, had previously been admitted to a mental hospital: patients were spending less time in mental hospitals, but they were more prone to be back in again later in life. One psychiatrist tartly observed that the 'open-door' policy had become a 'revolving door' policy.

There were also problems in the provision of community services. A study in 1974 of services in the northern metropolitan region of Sydney found low staff morale and poor teamwork. The links between community services and mental hospitals did not work well, and the range of treatment and rehabilitation programs was too narrow. While some regions were well serviced others were starved of funds and therefore understaffed, and what staff they had were poorly trained. One consequence of these problems was 'dumping'. Community workers with heavy loads sent difficult cases to hospitals without exploring community alternatives, while hospital psychiatrists, told to decrease the number of resident patients, sent many for placement in already-overburdened community facilities.

Discharged patients had to face many difficulties. Finding employment at any time was hard for them, and became increasingly so in the 1970s as unemployment rose. Most lived on pensions and relied on sheltered workshops. Geriatric patients were discharged from 'back wards', where they had wandered the hospital grounds with little interference, into cramped nursing homes where they were confined to beds for long periods. Many patients drifted after discharge towards hostel and boarding house ghettos, close to mental hospitals, where they were kept going on high drug dosages and had little contact with friends or relatives. They remained a dependent group. Placement, then, was more often 'a euphemism for transfer from one institution to another'. The release from hospital of the aged, infirm, retarded or mentally ill could be a severe strain on families, particularly on the women who had to care for discharged relatives. It was often easier to transfer patients from one institutional milieu to another.

Although it was clear that the policy of community treatment had not solved all problems, supporters of the new way argued that increased funding would yield solutions. In 1983 the report of the Richmond Inquiry in New South Wales became the most explicit official endorsement of the community treatment policy. This inquiry, headed by David Richmond, a member of the New South Wales Public Service Board, was commissioned by the Wran government to conduct a

wide-ranging investigation into the state's services for psychiatric, geriatric and handicapped patients. The report reiterated arguments of the previous two decades in support of community services. The policy, it concluded, used available funds to the best advantage, was popular with most people concerned professionally with mental health, and was most successful therapeutically. The boldest recommendation was that all the state's large mental hospitals should be closed, and integrated community services created for all patients except the few who might require specialised care. And the report introduced descriptions of patients which broke with established medical nomenclature. The mentally ill would be called 'troubled individuals', the mentally retarded the 'developmentally disabled', and senile dements 'geriatrics'.

Responses were mixed. The New South Wales Nurses' Federation and the Public Medical Officers' Association both said that the recommendations were designed to cut treatment costs at the expense of patients' welfare. They argued that as the houses necessary for the policy of deinstitutionalisation to work were not available, discharged patients would be struggling for places to live.

The New South Wales minister for health, Laurie Brereton, accused these bodies of spreading 'deliberately misleading rumours' in order to alarm patients' relatives. It was the right of individuals to be 'quietly mad' in the community, Brereton said, and implied that nurses and staff of mental hospitals were only out to save their jobs.

But the report disturbed others besides health workers. Residents of Frenchs Forest in Sydney petitioned the government that they did not want discharged patients settled in their area. The families of some patients were concerned at the prospect of being forced to care for dependent relatives.

In August 1985 opposition erupted when nurses in most mental hospitals went on strike. They were joined by some members of the Public Medical Officers' Association. Community volunteers and relatives were forced to maintain minimum services for patients.

Nurses complained that the rationalisation of psychiatric services envisaged in the Richmond report would lead to 'loss of beds, fewer jobs and a serious decline in patient care'. They argued that community care hostels were being staffed by residential care assistants who were cheaper but inadequately trained. The nurses returned to work after almost a month, but warned that their opposition would continue.

The New South Wales government and many professionals nevertheless endorsed the Richmond report. Similar policies were being discussed in other states and it seemed likely that they would yield reforms throughout the country. But the final shape of community schemes could be affected by the actions of nurses, doctors and the relatives of patients who were striving to maintain elements of the old institutional system.

Community treatment would need more housing and more staff. It remained to be seen whether the money would be found. The system might not solve the problems of institutionalisation that it was designed to overcome. Critics thought that it would create boarding house ghettos and a proliferation of small institutions for the incarceration of the mentally ill, alcoholics, geriatrics and the mentally handicapped. Experience in Britain, Europe and the USA suggests that while many patients could benefit from community care, others would be caught in a twilight world of unemployment and hostel life, deprived of the trained nursing care they would have received in the old days.

New South Wales former health minister, Laurie Brereton, looks on in 1983 as David Richmond explains to the media his proposals about state services to psychiatric, geriatric and handicapped people.
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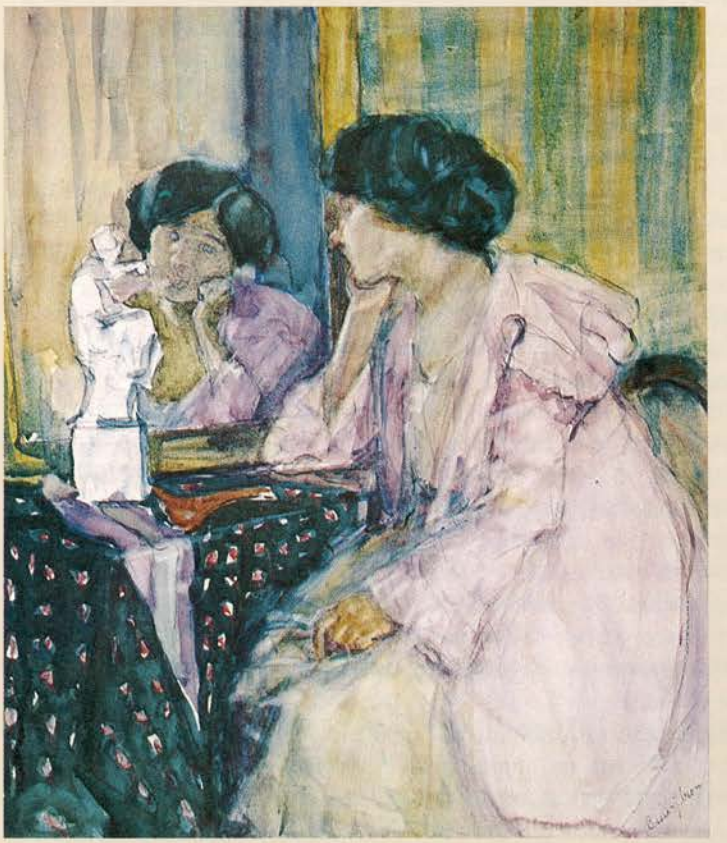

Bessie Gibson, Woman in a mirror, *1913, watercolour and pencil on paper.*
QUEENSLAND ART GALLERY

VII
TAKING STOCK

Talking over old times. *Speakers corner, Hyde Park, Sydney. Photograph by Kevin Diletti, May 1987.*