

COMMONWEALTH OF AUSTRALIA

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A BIOGRAPHY OF PSYCHIATRY

PROLOGUE

PARKSIDE MENTAL HOSPITAL - ABOUT 1930

On a still night, when the breeze was in the right direction, I would hear the cries; screams sometimes, but mostly calls; like female voices, calling.

It was a majestic building, a beautiful building really. I would pass it, in my father's car, on my way to school, along Fullarton Road. With its central tower and two three-storied wings, it was not unlike the main building of Prince Alfred College which I attended. But, situated as it was behind its high stone wall, it was a forbidding place. I knew that the cries came from there.

Later, they told me I had heard the peacocks screeching. There were a number of these birds in the mental hospital grounds. But I was not so sure.

I wondered how anyone could work in a lunatic asylum. In my mid-teens, my parents entertained a couple from Sydney, friends of friends of theirs. He was a doctor in Callan Park Mental Hospital in Sydney. He was such a normal, friendly, nice, interesting man.

It made you think.

CHAPTER 1

AN INTRODUCTION TO PSYCHIATRY - 1939 TO 1946

(i)

I came into psychiatry by accident.

I was born in Bexley, a suburb of Sydney, New South Wales, on 22 March, 1914. My early childhood was very over-protected. I was not allowed to run with other boys, climb trees, collect birds eggs, play rough games and so on. I became an avid reader and gained most of my adventure from comics, magazines and books. Cecil Rhodes, Clive of India and Kitchiner of Khartoum were my heroes.

When I was eleven years old, my father was appointed manager of a printing house and the family moved to South Australia. In 1928, I was enrolled at Prince Alfred College.¹ I did well. In 1932, I was made Head Prefect and Captain of the School and represented the School in Tennis. I was second to the Dux of the School and won a Commonwealth Scholarship to get into Medicine. It was during these years that I became very ambitious and it is little wonder that I set my sights on a Rhodes Scholarship.

In 1933, at the end of first year medicine, I was diagnosed as suffering from pulmonary tuberculosis. The diagnosis was the death-knell to my ambitions. I would not be able to play sport. I didn't think of dying; I wept that I would never be a Rhodes Scholar.

Now, my dreams and aspirations were in tatters. All I could expect was the absence of a year, at least, from my medical studies, and no competitive sport for goodness knows how long; that is, if I did get better. I could not contemplate, at that time, what the diagnosis would do to my social life.

I was given injections of tuberculin which was used in those days, and, later, had a pneumothorax. D'Arcy (later Sir D'Arcy) Cowan looked after me. He was in a sense a bush psychiatrist. He was warm and very reassuring; he constantly bolstered you up and kept your morale high. He had a couple of aphorisms: "You may look at the sun but not let the sun look at you" (He was against the body temperature being raised for whatever reason - a rise of 1 degree Fahrenheit from an infection put you straight to bed until the fever subsided); and "No fool was ever cured of tuberculosis". Later, in my psychiatric practice, I used to paraphrase this and say: "No fool was ever cured of a neurosis".

The tuberculin treatment was pretty trying. It went on for 18 months to two years. When I was back at the University, I would have the injection on a Saturday morning and spend the rest of the week-end in bed with a fever. It was like having a dose of 'flu every week-end. I suppose it taught me tolerance or something; it may have also made me a bit introspective.

In third or fourth year, I developed appendicitis, and, because of the T.B., I had my appendix out under a low spinal anaesthetic. A deep vein thrombosis developed in my left leg, followed by a pulmonary embolism. I can remember coughing up blood and being immobilized under morphia and so on. I was probably as near dying then as ever. And I had a retention of urine and had to be catheterised and it hurt like hell. I've been very sympathetic to people and the things doctors do to them ever since.

I graduated at the end of 1939, just after World War II was declared. As an undergraduate, I had attended the course in Psychological Medicine which was taught in sixth year. It consisted of twelve lecture/demonstrations. This represented probably the lowest number of hours of instruction in psychiatry in the Commonwealth. Three memories remain with me from this early period. The first two are of events that took place at Parkside Mental Hospital where the clinical demonstrations were held. A male patient was given an injection of "cardiazol" to induce a convulsion in the treatment of his psychosis. The group of medical students stood round the bed and watched this happen. The sight of the convulsion did not impress me; it seemed an unnatural thing to do. On a second occasion, a group of us were shown a manic patient as a demonstration. This rather small, thin, middle-aged woman pranced in and gyrated about, and showed

off rather like someone on the stage. I felt sure that she had been demonstrated to students before. The last memory was of being asked to describe the technique of full-coma insulin therapy in the final year examination. I can recall wondering what value the detailed knowledge of this treatment, that could be carried out only in a specialized hospital for the mentally ill, would be to me in my subsequent practice as a doctor.

In the middle of 1940, I went to Murray Bridge² as a general medical practitioner. I had had only six month's experience as a House Surgeon (as an intern). I was approached by Dr. F.R. Wicks to take over his country general practice so that he could volunteer for the Royal Australian Air Force. I accepted. I was motivated by two impulses: to do my bit for the war, by relieving a fit man to join the Forces; to be able to marry.

My outstanding impression of general practice was of anxiety: my anxiety over, especially, obstetrics and surgery. I really was very poorly trained. I was always terrified that some serious complication would occur that I would not be equipped to deal with.

Another vivid memory from that period was of the degree of morbidity from so-called minor conditions, such as infections round and under the finger nails. In the days before antibiotics, these conditions were terribly disabling for young housewives with children, who had constantly to have their hands in water. We were never taught how to deal with these in our medical course. This sort of experience made me very aware that minor deviations from normal could produce major consequences for the patient.

In 1941, a call went out to general practitioners to help relieve a shortage of doctors in the Army. The plan was that the practitioner would go into the Army for a month as a relieving medical officer in the camps. A colleague at Murray Bridge accepted the invitation. The other doctor and I carried on his practice. He came out of his month in the Army, bronzed and fit, and said it was the best paid holiday he had ever had. At the same time, I was becoming aware that the services of three doctors were not really necessary at Murray Bridge. There had been a movement of population out of the area: young men had

joined the Services; wives and other women had entered munitions factories and other war related industries, or just gone home to mother.

I offered my services for a month in the camps. The need for relieving medical officers became clear. I knew that my history of T.B. would render me unfit for overseas war service; but I thought I could be useful at home. So, I let it be known that I was prepared to leave general practice and join the army. Somewhat to my surprise my offer was accepted. I enlisted for full-time service on 1 October, 1941, with possibly the lowest medical classification anyone ever had, namely, "Class B2 - fit only for indoor duties".

I was posted to the Woodside Army Camp³ as a relieving medical officer. The majority of the troops in the camp were members of the A.I.F.⁴ and would be despatched to the various, overseas theatres of war. Woodside was situated in the Adelaide Hills and the weather was abominable. But, apart from this was the fact that I never felt part of any unit; I just relieved the regular medical officer while he was sent to a training course of one kind or another. It took about three months before I began to think I had made a terrible mistake in leaving home and general practice.

Relief came, however, when I was asked if I would like to "go to a school". I was not told what it was. But, to be sent to a school usually meant you were to be trained in some specialty of importance to the army establishment. I immediately accepted, as a means of escaping from the boredom of Woodside. It happened to be a school in Neurology and Psychiatry.

At the end of 1941 I went to Melbourne. The school was run by Dr. H.F. (Hal) Maudsley, Dr. J.F. (John) Williams and practically all the senior Victorian psychiatrists from the State mental hospitals, the psychiatric departments of the general hospitals and private practice. (Hal Maudsley and John Williams were instrumental in founding the Australasian Association of Psychiatrist in 1946.) We had lectures every day, sometimes into the evening. We read a lot. There were visits to hospitals. We had an opportunity to see patients under supervision. Convulsive therapy and full-coma insulin therapy were demonstrated, and the malaria treatment for the syphilitic nervous disorder, G.P.I., general paralysis of the insane. The lecturers provided us with a grounding in psychopathology. In twelve weeks, it was impossible to acquire

any but the simplest psychotherapy skills. The course was comprehensive, intensive and very stimulating. After the War, about half those who took part remained in psychiatry.

On my return to Adelaide, I was appointed to the 105 Adelaide Military Hospital, also known as the Daws Road Hospital. It is now the Repatriation General Hospital. I was the first medical officer at the hospital and did general duties until more staff was appointed and the psychiatric facilities were constructed. Then I became the psychiatrist full-time.

The psychiatric wards were of a temporary, wooden construction, but were, nevertheless, satisfactory for the times. The treatments were those I had learnt at the course. Convulsive therapy was used, the convulsing agent being the drug "cardiazol". Modified (sub-coma) insulin therapy was given for its calming, "tonic" effect. I did a good deal of superficial psychotherapy, mainly explanation, reassurance and suggestion. My interest in the need for complete openness and honesty with patients probably derived from this experience, because I found that a lot could be done for anxious soldiers returning from traumatic combat experiences, the so-called "war neurosis", by a thorough explanation of the nature of their symptoms and, in many cases, the physiological basis of the disorder.

I can remember helping some returned soldiers with severe startle reactions in this way. And there was one man who suffered from an hysterical paraplegia. I was able to demonstrate to him that he developed spasm of the agonist and antagonist muscles whenever he tried to move his legs. An explanation of the physiological nature of this disturbance, together with the elucidation of its psychological link with a precipitating traumatic experience, helped him to respond satisfactorily and fairly rapidly after many months of incapacity.

I had my first experience with narcoanalysis - that is, the attempt to produce a cathartic abreaction under a hypnotic drug, usually by the slow, intravenous injection of pentothal sodium or sodium amytal. I must confess that I was rather disappointed with this technique. The reports coming from the combat area gave glowing accounts of the beneficial results obtained. I could only conclude that the disturbances had become more deeply imbedded over the intervening months since the onset of symptoms and evacuation

across the seas to Australia, and that the repressed traumatic material was now less accessible. I used a little hypnosis, but I never had much confidence with this method. I consoled myself with the recollection that Freud himself had started off with hypnosis and given it up.

The induction of a convulsion by intravenous cardiazol caused me much anxiety. Only the satisfaction of seeing depressed patients get better kept me going. Cardiazol was given as a large injection, usually 6 to 8 ccs, depending on the weight of the patient. A large bore needle was used because it had to be injected fast. The speed of the injection often determined whether the patient had a convulsion or not. If the patient convulsed, well and good. If not, then you had to give a second larger injection as fast as possible to prevent the terrible effects a missed convulsion was supposed to have. It was alleged to produce a sense of utter dissolution. The only way to avoid this was to induce a second convulsion; the consequent retrograde amnesia would mask the unpleasant sensations. The missed convulsion made the patient apprehensive and restless. It was no fun trying to get into a jumping, bobbing vein, using a large syringe with a cc. more than the first injection, and to push it in as fast as one could. In the end, I became as apprehensive of giving cardiazol injections as some of the patients became of taking them. It was a vast improvement, and a relief to me, when the drug was replaced by the electric current, by electroconvulsive therapy (E.C.T.).

Convulsive therapy was introduced originally by von Meduna in 1934, in the mistaken belief that there was a certain biological antagonism between epilepsy and schizophrenia. Then it was found that it often relieved the affective side of the illness, but not the thought disorder, and it became the treatment of choice for the affective disorders.

The drugs used were limited. We had bromide, chloral and paraldehyde for sedation. The safest was paraldehyde. The great disadvantage was its powerful smell. It was excreted in the breath and the ward would reek with the pungent, distinctive smell if it were used at all extensively for night-time sedation. There were barbiturates, such as phenobarbitone, veronal and medinal, and the longer acting drug, sulphonal.

In about March 1943 I became ill with a pneumonia, and an X-ray opacity showed up in my left (the good) lung. The Army medicos thought it was my T.B. flaring up and got rid of me quick smart. I had by then decided that I should train further in psychiatry. I applied to enter the mental hospital service. Bill Salter, as will be revealed later, came into the Army and I went to Parkside Mental Hospital.

The history of the hospital, commemorating its centenary in 1970, was written and prepared by Mr. H.T. Kay, who will be referred to later in this story. He was then the Lay Superintendent of Glenside Hospital, as the Parkside Lunatic Asylum 1870-1913, Parkside Mental Hospital 1913-1967, was now called. In the Forward, the then Chief Secretary, The Hon. R.C. DeGaris, M.L.C. wrote:

"Mr Kay entered the service of the Hospital in 1920, and his service to the Glenside Hospital has consequently spanned 50 years, or half the entire lifetime of the Hospital. This book has been a labour of love for him, and I am certain that all who peruse its pages will find something of interest and some reflections on the early days of this State."

Parkside Lunatic Asylum was the third asylum in South Australia. The Public Colonial Lunatic Asylum was established, in a rented house, in May, 1846. The Adelaide Lunatic Asylum opened in 1852. It was in use for fifty years, closing its doors in 1902 when the remaining patients were transferred to Parkside Lunatic Asylum which had opened in 1870. As Kay pointed out, fate had it that the Hospital was built on the site of the original house on the eastern plains where the Public Colonial Lunatic Asylum had been established. I wholeheartedly agree with Mr DeGaris that anyone interested in the beginnings and development of the State Mental Health Services should read this book.

I was a resident medical officer at Parkside Mental Hospital from 1943-1946. For the year 1945-46, the average daily number of patients resident was 1,387, made up of 628 males and 759 females. (Incidentally, Kay records that, on 23rd May, 1958, the number of patients in Hospital was 1,769, the highest number in Hospital on any one day since the Hospital opened in 1870.) Beside Dr. H.M. Birch, the Superintendent, there was the elderly, Scottish Deputy Superintendent, Dr. Gilbert Aitken, and three medical officers. I was in charge of one quarter of the hospital, the patients in the front half of the female section. It must be

remembered that the hospital was bisected by an east-west line, through the centre of the Administration Building, with male patients to the south and female patients to the north. I was fortunate in that the more acute patients were to the front. This system was common to most mental hospitals; so the term "the back wards" referred to the chronic, more hopeless, least interesting patients who dwelt there. On one weekend in four I would be the only doctor on duty for the whole hospital. Of the medical staff, those who taught me most were Dr. Birch and Dr. K.B. Winter.

(ii)

Karl Berthold Winter, commonly known as Charlie, migrated to Australia in October, 1939. He had done his preclinical years in Berlin, Germany, and his clinical work in Heidelberg and Freiburg, graduating in 1923. Psychiatric experience was obtained at a mental hospital near Heidelberg and at the University Clinic in Heidelberg. He completed his thesis in 1924. Between 1926 and 1928, he had psychoanalytic training with Dr. Hans Sachs, one of Freud's early disciples. (Incidentally, Lotte, Charlie's widow, informed me that Sachs was a lawyer!) Later, Charlie used to say that he parted from psychoanalysis because he could not accept Freud's "pan-sexualism", though he was comfortable with many of his other propositions.

His wife, Lotte, revealed that she had Jewish forebears; but she declared it was not for this reason that Charlie decided they should leave Germany. He had been a prisoner-of-war in Britain during World War I. Being proficient in English, he had actually acted as an interpreter. During this time, he was treated well and he developed a sympathy for and appreciation of British law and justice and the way of life. He was offended by the threatened encroachment on civil liberties and personal freedom that was part of the Nazi doctrines. So, with his wife and two daughters, he left Germany and came to South Australia.

At that time, as now, Germany had no reciprocity with Australia and German medical qualifications were not recognized. Charlie was required to undertake the last three years, the clinical half, of the medical course at the University of Adelaide. He graduated M.B.,B.S. in December, 1942. After doing locums in

general practice, he obtained a position at Parkside Mental Hospital in June, 1943. Lotte informed me that, even though he was registered as a legally qualified medical practitioner in South Australia, as a German alien, he was not employed within the Public Service, as Australian graduates were. He was also paid at a much lower rate; so much so, that, in 1945, he advised Dr Birch of his financial position, and went into private practice.

It was during the years 1943-1946 that I came to appreciate Charlie Winter, both as a man and for his psychiatric skills. He was an excellent clinician, wide in his knowledge and wise in his counsel. Much of what I learned I owed to him. It was for this reason that I, with some others, fought to have him admitted as a member of the Australasian Association of Psychiatrists.. Under the then regulations, his German psychiatric qualifications were not recognised as fulfilling the requirements for admission. Eventually, we were successful, and his undoubted abilities were acknowledged. Charlie Winter died in January 1972, aged 73 years.

(iii)

At that time, at Parkside Mental Hospital, the Nurses were poorly trained and the wards were understaffed. Only a few of the more senior female nurses had any general hospital training; few males were trained, as their title "male attendant" suggested. Kay pointed out in his book that, for many years, nurses had been given twelve lectures per year for three years by the medical staff. If successful they were entitled to register as Mental Nurses with the Nurses Board of South Australia. From 1924, because of the dearth of nurses with a General Certificate employed in the mental hospital, selected nurses with a mental nurse registration could be seconded to the Adelaide Hospital for general training, a condition being that they returned to the Hospital after the successful completion of their course. As a result, in time, nurses in the more senior positions had the General Certificate. In 1964, the Nurses Board of South Australia was given legislative responsibility for training, and new syllabuses were introduced resulting in separate registers for

resulting in separate registers for Psychiatric Nurses and Mental Deficiency Nurses. Lecture hours escalated to 237 hours for the three years of training.

In the 1940's, the overcrowded, understaffed wards made the use of physical methods of restraint both necessary and acceptable. There were a number of these restraining devices. The commonest was the straight jacket: a canvas jacket, fastened up the back, with sleeves that ended in canvas straps; the arms were thrust into the sleeves, crossed over the chest and the straps were tied behind the back. This garment kept the patient warm and also prevented the patient from attacking the staff. It did not prevent kicking. Leather ankle straps, linked together, did prevent kicking, as well as any attempt to run away if a gate from an airing court were open to let working patients through. For less violent patients, who, however, may be destructive of their clothing or their own person, muffs were preferred. These were leather containers, joined together, into each of which the hands were inserted and kept in place by straps locked above the wrists. Another garment was the camisole. This was a long suede jacket, rather like a nightdress. It encased the whole body and, again, was laced up the back. It was useful for patients who stripped themselves or had a tendency to self-mutilation.

Restraint was also used in melancholic patients who, with suicidal intent, stubbornly refused to eat or drink. The only way to give life-saving nourishment was by tube-feeding. Some would vigorously resist the attempts of staff to assist while the doctor inserted a large bore rubber tube down the oesophagus into the stomach, through which a mixture of milk, eggs and "vegemite" et cetera was poured. Extreme care had to be taken that the tube entered the stomach; an inhalation pneumonia was the nasty alternative. Some form of physical restraint made the procedure safer and reduced the wear and tear on the nurses.⁵

In retrospect, these methods of control appear barbaric; and in a sense they were. We know now that the behaviour arose, not only from the mental disease from which the patient suffered, but also from the effects of deprivation of liberty, of over-crowding and the loss of identity that admission to a mental hospital entailed. It must be remembered that, apart from sedation, there was then no chemical way of modifying violent behaviour. The care was largely custodial, until the physical methods of treatment were introduced.

The hospital was, of course, a closed institution. Windows were barred; doors giving access to, or egress from, an airing court or a ward were locked. All staff carried a large bunch of keys.

In 1943, I occupied a large house in the hospital grounds facing Greenhill Road. I recall that I would walk across the large area of market gardens that then occupied the northern parts of the grounds and unlock a gate in a high, galvanized iron fence in order to enter the Hospital. I would find myself in an airing court to one of the female wards. Another solid wood door had to be unlocked, and locked behind me, for me to enter the central courtyard of the main building. This ritual of unlocking a gate or a door to enter an area or ward and of locking it behind accompanied me wherever I went. When on a hospital round, the ritual was performed by the nurse in charge of the ward being visited. As Dr. Bill Salter describes so graphically later in this history, the escape of a patient was viewed very seriously and the prevention of escapes was high in the nurses training and list of responsibilities.

In 1945, I had the opportunity to work at Enfield Receiving House⁶ for nearly ten months. At that time, there were two mental hospitals in South Australia, Parkside Mental Hospital and Northfield Mental Hospital⁷. The only receiving house then was at Enfield.

Enfield Receiving House was an 80-bed hospital which received all the 10th schedule admissions in the State. These were the people who, under the Mental Health Act, were certified, on one medical certificate, as being apparently mentally defective. I had the administration of this Unit, under the nominal supervision of the Superintendent of Mental Institutions, Dr H.M. Birch. It was my first experience in running a hospital, and I gained experience there that stood me in good stead when, years later, I became Director of Mental Health Services. The Hospital had a first-rate matron, Matron Frieda Eime, who was literally in charge of all staff, nursing and lay. She was a great support.

At Enfield, I had to diagnose patients and manage them as I saw fit. Those who had chronic disease or looked as if they would not respond readily to treatment were transferred to Parkside Mental Hospital. Others I treated and then transferred if they failed to respond in a reasonable time, or if pressure of admissions meant that I had to empty beds by transfer. Still others were treated and subsequently

discharged. Such triage, by one as inexperienced as I, may have been disadvantageous to some; but, for me, it taught me to work under pressure and to trust my own judgment.

I used a whole range of therapies at Enfield: full-coma insulin, sub-coma insulin, ECT, malaria for G.P.I., sedatives, mainly barbiturates and paraldehyde, and, for really disturbed patients, injections of morphia and hyoscine. Physical restraints were used rarely, though there was a padded room available. I had the opportunity, for the first time, to undertake psychotherapy of the longer term, analytic variety. It was here that the desire to go abroad for psychoanalytic training was born.

It was in 1943, also, that I was asked by Dr. H.K. Allen (commonly known as "King" Allen) to establish the first psychiatric outpatient department in South Australia for the Repatriation Department. At Parkside Mental Hospital, we had two half-days a week leave to compensate for night and weekend duty. I was given permission to attend the Keswick Hospital⁸ Outpatient Department on one session per week for the payment of three guineas for a three-hour session. This was in June 1943. In October 1945, this was increased to two sessions per week at the same fee per session.

At this outpatient department, I undertook consultations for other specialists and reported my findings and recommendations; I did some brief psychotherapy and drug therapy. There was no opportunity for inpatient treatment, though, while I was at Enfield Hospital in 1945, some patients of the Repatriation Department came to the Hospital as voluntary patients for inpatient treatment under my care.

During this period, I gave lectures in physiology at the University of Adelaide for Acting Professor Hugh LeMessurier for post-graduate courses being conducted by the various Colleges, mainly the College of Physicians. I also delivered a number of lectures on psychiatry for the Red Cross Society, and there are copies of these papers in my collection of reprints.

The ten months I spent at Enfield Receiving House, while Dr H.M. Southwood was on long service leave, (this is referred to elsewhere) was a great time of intensive experience. It had the effect of unsettling me when I returned to Parkside Mental Hospital in about the October 1945. The relative inactivity got me

down. So, I started a course of full-coma insulin therapy with four male schizophrenic patients. I used the small ward attached to the operating theatre; the Deputy Matron, Sister Sullivan, assisted with the provision of nursing staff. With hind-sight, I think this could be seen as an infringement of the human rights of these patients. None of them had a good prognosis; none of them were asked to accept the treatment. None of them showed any improvement. But, in the therapeutic climate of the time, I felt I had to keep trying to get people better. After all, I did have some successes at Enfield.

The course of treatment was well under way when I was summoned by Dr. Birch. He informed me that it would have to stop, because of shortage of staff: the male nurses who were closely supervising the full-coma insulin treatment were needed for the coming Christmas Carnival. To say the least I was not pleased by the implication that a carnival should be considered to be more important than legitimate medical treatment. I must now concede that Dr. Birch was right. He knew that the prognosis of the patients I was treating was very poor: he probably recognized correctly my motives for undertaking it. What was more important was that the Christmas Carnival, held every year at Parkside Mental Hospital, involved a great number of patients and staff. The Premier, the Minister of Health, other important people, relatives and friends, and members of the public would attend. Dr. Birch had some moving pictures of some of these carnivals taken and the films can still be viewed.

The Carnival, a Fair really, would be roundly criticised today. Patients, and some of the medical, nursing and other staff, dressed up in fancy dress costumes, rode in decorated floats, and took part in races of various kinds. It did put the patients on show, and this would not now be tolerated. However, it was a form of occupational therapy. Patients and staff would work together for months, making floats and getting ready for the big day. The people who enjoyed it most were the mentally retarded, who constituted about a third of the population of the Hospital. Impassive schizophrenics were led around by staff. But, there was excellent patient-staff involvement. Members of staff competed with patients and each other in the races. Bill Salter, a good athlete, recalled with pleasure his participation in these events.

But, at the time, I was upset that I had to stop the full-coma insulin. It seemed to me that Dr. Birch had his priorities wrong. One should be trying to treat people, not, in a sense, putting them on parade for the curious public. So, my frustration at returning to Parkside, where I seemed just to be marking time after the stimulating ten months at Enfield, was topped up by this current, perceived injustice, and I decided I should leave the mental health services.

CHAPTER 2

BC - "BEFORE CRAMOND".

(i)

It was the opinion of some that, when Hugh McIntyre Birch retired on 8th July, 1961, the greatest obstruction to progress in psychiatry and psychiatric treatment in South Australia stepped aside. This harsh judgment was not shared by all. Harry Kay, who was at Parkside Mental Hospital when Dr. Birch came and was there when he left and had served him for 26 years, the last five as Lay Superintendent, expressed this opinion: "He was a hard man really. But, underneath it all, he had a very soft spot and he was very charitable". His successor, Dr. W.A. (Bill) Cramond, said:

"In a funny sort of way, Birch was very forward looking. He was very good with his hands. He was interested in electrical matters and things mechanical. He'd actually built himself, from plans, the first E.C.T. machine in South Australia. He had encouraged the use of leucotomy and there was a little operating theatre where leucotomies were done in the Hospital. So he was forward looking and enterprising in that sort of way."

So what sort of man was this of whom old staff, who used to abuse him for this and that and call him all sorts of names, could say later to Kay: "I wish we had old bugger Birch back again".

Hugh Birch was born at Glenelg, South Australia, on 4th December, 1895, of Scottish immigrants. They were religious and worthy parents who were, or became, Plymouth Brethren. The Birch's were brought up in a very strict household. He was educated at Pulteney Church of England Grammar School.

At the age of 15, he had an accident which left him with a severe disability, and an increasing lack of mobility that plagued his later years. The events surrounding the accident give an indication of the basic qualities of the man. As an adolescent, Birch was a tall lad, nearly six feet tall and athletic. One afternoon he came home from school, got his bike and went down to the beach at Semaphore to where his parents had moved. He rode along the beach at a fast pace and hurdled the big clumps of seaweed. This was quite a craze with the lads at that time. He did this once too often. He hurdled a fairly large lump, came down with a crash on the far side, landed on his head and lay still. He had broken his neck.

During the two years Birch lay on his back in hospital without being allowed out of bed, his arms recovered to some extent. There was only limited improvement in his legs. After two years, he was allowed up to see what he could do to try and strengthen his legs, and from then on he got about with his spastic, shuffling gait.

Those who knew Birch described him as a man of great determination and strong character, and, with this grit and determination, he decided to go back to his studies. With the aid of a tutor, he matriculated some four years late and then entered the University. He did the equivalent of first year at that time, physics, chemistry and zoology/biology in 1918, and commenced the Medical Course at the University of Adelaide in 1919. He was described as a careful, painstaking student, working assiduously and meticulously. At the University, he was a well-known character not only for his shuffling gait - he could not get his feet off the ground and moved along by pushing one leg forward on to the other - but because of his intense interest in sport. He was a keen rifleman and was in contention for a place in the University rifle team though he did not actually make it. None-the-less, he became a member of the rifle club and subsequently the secretary and team manager, taking part in inter-university contests. He also was made treasurer of the University Sports Association and was awarded a University Blue in 1923, purely because of his interest in the sports and the wonderful work for the Association.

At the end of Fifth Year in 1923, he failed the examination. It is said that Birch believed that this was due to one very senior honorary physician who had his knife into him. To be fair, it is possible that this elderly gentleman was trying to bring home to Birch that, with his awful disability, medicine was not going

to be his best bet and was trying to put him off. Birch responded by sailing for England in 1924. He passed the conjoint examination of the Royal Colleges of Surgeons and Physicians (M.R.C.S.,L.R.C.P.) in 1925. After graduation, he worked for a time in London Hospitals before deciding to return to Australia.

He got a job on a freighter that was coming west across the Atlantic and through the Panama Canal. Once more misfortune struck and the ship was wrecked on a reef in the West Indies. They were rescued by another ship.

However, this involved being transferred by small boat and climbing up the side of the rescue ship by a Jacob's ladder (a rope-ladder). This was an awful ordeal and he took a long time to get up; but he did get up. The rescue ship was making for New Zealand and Birch was dropped off there, later making his way back to Australia.

Back in Adelaide, he did locum work, one with Dr. "Jimmy" Burnell who was one of the first specialists in urology. However, in 1926, he applied for and was appointed Junior Medical Officer at Parkside Mental Hospital. It is not clear whether Birch had any prior interest in psychiatry, or whether experiences during his medical course, in England after graduation and with Burnell in Adelaide had convinced him that his physical disabilities precluded him from entering a number of types of medical practice. Thus began an association with Parkside Mental Hospital lasting 35 years, during which he was appointed Superintendent of the hospital and, later, Superintendent of Mental Institutions and Director of Mental Health.

As a young graduate, Hugh Birch had a great interest in motor cars. Dr. Dudley Byrne¹ spent a year at Parkside Mental Hospital in 1931 as the fourth medical officer, and became friendly with Birch who was the third medical officer. This friendship lasted until the latter's death. It was Byrne who had custody of Birch's OBE insignia and other documents and made them available for display in the H.M. Birch Library at Glenside Hospital.

He told the story of the time when Birch challenged Dr. A.J. (Jimmy) Burnell to a motor car race. Birch was assistant to Burnell at the time. The challenge arose out of Birch's belief that his "Rover" was a

better car than the one Burnell was driving. The challenge was accepted; the race was to be from Adelaide to Gawler. As Burnell had a more expensive car and had had much more experience with motor cars he said that he would give Birch a start. They would both leave as the clock struck 7 o'clock in the morning: Burnell would leave from his home on the corner of Hutt and Wakefield Streets; Birch would leave from Gepps Cross. Burnell bet "Hughie" a sum of money that he would get to Gawler first. Both were very shrewd and stripped their cars of everything that could delay their progress.

One Sunday morning when there was no traffic about, they set out. Birch told Byrne that he drove like mad. When he stopped at Gawler Town Hall and listened, he could hear the roar of Burnell's car coming up the road. Birch won that race, but it must be admitted that it was a handicapped race and he had a hell of a start.

All through his life, Birch continued to show a liking for large, expensive cars. Of course, he had to buy a car with large front doors and the space for him to lever his body in behind the steering wheel. I recall his driving a large Chevrolet. John Cawte told a story that involved a blue Jaguar.²

There are varying opinions of Hugh Birch, depending on how he was viewed by those who knew him. There is no doubt about his high principles. Dudley Byrne stated that "in the opinion of the Government, he was a very honest, very trustworthy man and the more one got to know him the more one realized just how true that was. He was strongly of the opinion that the Government's money was not to be used for purposes other than for what it was granted to the hospital". This very conservative attitude led, of course, to the opposite, less complimentary point of view. Bill Salter told of the time when a truck was urgently needed at Northfield Mental Hospital. Dr. Birch had quite a bit of money left over at the end of the financial year. He dutifully returned the money back to the Government. Salter, who did not get the truck, said: "Everything was skimped. If he could possibly make something do, he would. Food was poor and equipment like chairs and beds ancient".

Stories abound which represent him as unbelievably mean. Dr. Lothar Hoff³ recounts a story about the time Dr. John Cawte was at Enfield and trying to open up the place. He was anxious to have a clinical

meeting for the Australasian Association of Psychiatrists (S.A. Branch) and thought to use the Occupational Therapy room for the meeting, which was out the back and some distance from the main building. He rang Dr. Birch to get permission to have an electric light extension fitted over the door for the convenience of those who would attend. It is alleged Dr. Birch asked Cawte to hold the line for a minute; and then came back on to tell him that there would be a full moon the night of the meeting and the extra light would not be necessary.

Harry Kay was much more charitable - Harry Kay, a most loyal servant, often described as Hugh Birch's legs, and even his ears and eyes as well. As he pointed out, Birch took over in the middle of the Great Depression; then came the Second World War. He had a hard time really; he went through some very hard years. It was practically impossible to get any money at all. But he tried. He was seen as a hard man, but one who stood by his decisions.

There was no doubt about his courage. The photograph in the Board Room at Glenside Hospital as a young man, presumably when he was appointed superintendent, shows his square jaw thrust out defiantly at the obstacles that beset him. He had taken himself off to England again in 1932 to obtain more experience in psychiatry, and obtained the Conjoint D.P.M. He was appointed Superintendent in 1935. Byrne said: "He never shirked anything that I knew of. Cramond pointed out that Birch was a big man with a powerful voice and his strength was very obvious. "He could be a very formidable man when he was angry; when he was frustrated and angry he could be a very awkward customer".

As Birch grew older, he became more disabled. He put on weight and this added to his difficulty in getting around. When he did visit the wards the staff had plenty of warning and the opportunity to hide things they did not want him to see He could never just drop in unannounced. He ran the hospital and the rest of the Mental Health Services from his office at Parkside Mental Hospital. He visited Northfield and Enfield, as it were, by appointment. His disabilities and his personality combined to reveal those attributes and activities for which he could be most admired and most criticised. He was seen by some as a man of indomitable will who overcame gross disability and worked with inflexible purpose to carry out his responsibilities; a man of complete honesty and sterling worth whose heart was filled with compassion for

the mentally and physically disabled. To others he was a massive obstruction to progress in psychiatry and the care of the mentally ill in South Australia.

Kay, who must have known him as well as any other associate, described him as being very charitable with a soft spot underneath. He described an incident when, on his last day of duty, Birch avoided a presentation of presents from the staff to mark his retirement, by actually going home early. Dr. Brian Shea and Kay were therefore deputised to take the presents to his home. Mrs. Birch insisted they come in and see Hugh himself. Kay said: "We went in and he had tears in his eyes and was full of apology. He said that he would have made a fool of himself if he had stood to receive a presentation, as he was too emotionally upset. That was the softer side of his nature. He really cried".

I knew Hugh Birch as a medical student, but more closely during the three years I was at Parkside Mental Hospital. After being "trained as a psychiatrist" in the Army and subsequently discharged as medically unfit, I went to Parkside from 1943 to 1946. He was a complex character. His ambivalence shone through. Mostly you saw him as authoritarian, rigid, parsimonious and meticulous. This attitude had its good and its bad impressions on me. His uncompromising view of the law is recalled with gratitude. It stood me in good stead in clinical practice and in the writing of the new Mental Health Act. Birch had no doubt on the value of the McNaghten Rules. His constant use of them in discussion helped me to become clear in my mind about what constituted a psychosis, and, especially, what mental illness justified involuntarily admission to a mental hospital. His emphasis that a doctor should always be able to justify his medical certificate in a court of law demanded that you became precise in your thinking. I have been unable to countenance muddled thinking ever since. Unfortunately, adherence to rules for their own sake could lead to frustration and irritation in others and no doubt magnified the adverse image for which, unfortunately, he seems largely to be remembered. I became a personal recipient of this.

Dr. Owen Moulden was Honorary Surgeon to the hospital. He was one of the competent general practitioner surgeons who were the rule rather than the exception in those days. It was one of my duties to assist him with the operations he performed in the operating theatre that Hugh Birch had caused to be built at Parkside. With so many doctors enlisted in the armed forces, it could be difficult to obtain assistance. It

did not surprise me when Moulden asked me if I could assist him with a private operation. I gave the invitation positive consideration because I believed that, by helping Moulden, I could do a bit more for the war effort. I went to Dr. Birch and told him of Moulden's invitation. He gave permission, though he took pains to point out that, as a public servant, I could not accept a fee. As no fee had been mentioned, this warning did not concern me. Dr. Moulden informed me that the operation would be at, I think, 11.30 a.m. in a few days. On the appointed day, I got up early and did my hospital round and other duties before I reported to Dr. Birch's office at about 11 a.m. I was conscientious and fairly meticulous myself, so I had made sure the morning's work was done. When I informed Birch that I had finished my work and was ready to leave to assist Dr. Moulden, a thunder cloud literally came across his countenance. His face was suffused with anger. He said that he had expected me to assist with the operation on my afternoon off and that it was all very irregular. He conceded that as the operation had now been arranged I should have to go. But he permitted this with great reluctance and again reminded me that I could accept no fee. Moulden thereafter did not ask me to assist with operations on his private patients.

John Cawte, who had strong views on Hugh Birch, and whose story will be told later, had another explanation for Birch's parsimony and how he could take small grants from the Government and manage to give some back, even in spite of what everyone else saw as pressing needs. Bill Salter has given a telling example of this. It was Cawte's belief that Birch had been strongly influenced by the writings of Henry Maudsley, one of the great names in late 19th century psychiatry in England. He had a set of his books and lent one to Cawte in his early days at Parkside.

Maudsley used to refer to the psychiatric problems, and also to criminals and idiots, as examples of a "degenerate constitution". "Constitution" was his magic word. He argued that it would be foolish to spend money on such people. Look after them, but do not try to get them better. It was a waste of time and money putting it into a set of "old hacks" and trying to make them into "race horses". It was a very powerful point of view and was widely adopted in England at the time. Cawte had come to the conclusion that Birch's obsessive saving of money did not signify a neurotic personality. Rather, he had in his mind a well-formulated philosophy, derived from Maudsley, that governed the way he would look after the hospital and his patients.

Hugh Birch did have a kind, gentler, considerate side. While at Parkside, I developed severe lower bowel symptoms, which were diagnosed as being due to a stricture that had resulted from a tuberculous ulcer in the rectum that had occurred some years previously as a complication of the pulmonary tuberculosis. Surgery was required to relieve the stricture, which then had to be kept dilated by the regular insertion of a dilator. Hugh Birch showed concern for my condition and its long-term treatment. He offered to make the necessary dilator on his lathe. I accepted his offer. It was turned out of brass and then electroplated with nickel-silver. It was beautifully done. I used it continuously for years until experience showed that the treatment was no longer necessary. Of course, he refused to accept any payment.

I am sure that I had him to thank for putting me up as a Foundation Member of the embryonic Australasian Association of Psychiatrists, and so opening the door to one of the avenues for my future interest and achievement. I liked him but with not much warmth. I never saw him again after he retired.

(ii)

Harry Kay is the link between the old and the new eras, between Hugh Birch and Bill Cramond, and is an important link in the chain of this story. Harry Kay was, as history tells, fifty continuous years at Parkside Mental Hospital. But this does not explain his real value. It was his loyalty that was so outstanding; first to Hugh Birch and then to Bill Cramond; and, more surprising for few thought it would have been possible, his capacity to change and to assume responsibility when it was thrust on him.

Harry Kay started at Parkside Mental Hospital on 2nd March, 1920, on his 15th birthday. He admitted that never at any time did he think he was going to spend the whole of his working life at the hospital. When his father heard that he had got a job at the Mental Hospital he said: "I'll give you a fortnight; you will not stay there longer than that". But he stayed on, first as the Junior Clerk, later as Clerk and then Chief Clerk and, for the last 14 years, as Lay Superintendent. He served under five Medical

Superintendents. Dr. Downey was there at the time of his appointment, with Dr. Alexander Jamieson Meikle as his Deputy and Albert Botting the Chief Clerk and Steward.

Kay did the typing up until about 1937 when a Miss Stone came from the Hospitals Department as typist. He recalls that Dr. Downey gave him some typing on a Thursday before Good Friday in 1933. "I said: 'I don't know if I'll be able to finish it for you, Sir, before you go off tonight'. He said: 'Tuesday will do, Harry'. He died on the Sunday or Monday, so he never signed that one."

Dr. Meikle was there for a very short time. He was just about to retire when Downey died. This led to the appointment of Dr. Birch as Superintendent in 1935 as a relatively young man.

Harry Kay was one of the characters Colin Haynes⁴ most admired. For years he had been steeped in the tradition of Dr. Birch, namely: "You couldn't spend a penny without all the approval in the world". By comparison, Dr. Cramond and Howard Lloyd⁵ had new ideas of administration that were quite loose: "You go your hardest, do everything off your own initiative, spend the money and get things done". With Dr. Birch, Kay had been his feet and his eyes and his ears. So it amazed Haynes how well Harry made the adjustment and become a very progressive administrator from probably the most conservative one. Haynes said: "I think Harry could have served a useful purpose by giving lectures on the practical aspects of administration. He was a legend in his lifetime". Kay himself said simply, referring to Dr. Cramond: "I had a lot more responsibility placed on my shoulders". He clearly accepted it, appreciated it, responded to it and enjoyed it.

Cramond believed that Harry Kay should have had some reward, an award such as an M.B.E., for his 40 years of very loyal service and his ability, late in his career, to change his style to meet new demands and new needs. After all, it was not everybody who could do that and do it well. Cramond did put up the suggestion but it was not taken up by those in authority. He said:

"Kay was really Dr. Birch's scout, his trouble-shooter, his pair of legs; he did everything for him. He was tremendously loyal. And, here was I, fresh from Britain, suddenly undoing and just dismantling everything that Hugh Birch had stood for; and, though he obviously found it traumatic to cope with this young whipper-snapper, yet he transferred his loyalty. He was a man of great

personal integrity and he remained loyal to Dr. Birch. But he saw that times had changed and that there were other ways of doing things; and he therefore tried honestly to carry out what I asked. He then discovered, of course, that it worked and he became tremendously enthusiastic and was a very great help."

(iii)

In 1952, Barbara Franck (now Auld) was employed as social worker at Parkside Mental Hospital.

When her first husband was killed in the Second World War, she had become eligible under the Commonwealth Post-war Rehabilitation Training Scheme and had decided to go to the University on the allowance and do Social Work. She had had an interest in psychiatry before then as she had attended some W.E.A. classes given by Mary Smith, the psychologist, who was a good lecturer. In the Social Work course arranged by Mrs. Amy Wheaton there were also some excellent lecturers, such as Dr. Karl Winter, the psychiatrist, Amy Wheaton herself, and some other top people. This was the aspect of social work that interested her most.

However, she never intended to work in psychiatry as she had married again. After two years with the Family Welfare Bureau, she decided to look around for another part-time position. The vacancy at Parkside Mental Hospital was mentioned to her and she applied for what she thought was a part-time position. She got the job - full time. She had 1600 patients to look after, all "bottled up" in this hospital. "The place was jammed to the windows".

The first social worker at Parkside, Susan Jeffries, had started in about 1947. She stayed for two years. Then there was Joan Warner for a year; then the two year gap before she was appointed.

"I inherited rather more than I had anticipated. I was interviewed by Dr. Birch. He saw everybody. He kept his finger pretty much on the pulse of things. I had done a Handicraft course

with Red Cross and worked at Northfield Military Hospital teaching weaving with the convalescent patients. Dr. Birch was not very sure of the value of these qualifications, but decided to give me a try."

She found that the hospital buildings were very old and decrepit. There had been plans for rebuilding but these had been shelved because of the War. The diagnostic categories covered absolutely everything, including the criminally insane in Z ward. There were the so-called ineducable that Minda Home (a charitable, non-government organization) had unloaded during the War. There was every age from 6 months to 103 years. The 109 year old was an aboriginal woman who had been admitted at the age of 64 with senile dementia and had survived for another 39 years. Barbara pointed out that this woman had brought out Dr. Birch's liberalism: he allowed her to have a pipe and tobacco, like the men, as she was used to smoking. She was the only woman in the hospital who was allowed to smoke.

Behind the walls there was a whole township. There were all kinds of workshops and artisans. There was a carpenter shop, a bootmaker's shop, a tailor's shop and a dressmaker, a blacksmith, a kitchen, a laundry and a large garden. The patients used to help in all these areas. Including the staff, professional, nursing, clerical and artisan, and the patients, there was a population as big as Waikerie or one of the Murray River towns. The community outside was quite oblivious of this, for there was hardly any exchange: if you didn't have a relative to visit you didn't go in; and very few went out in those days either.

"I was taken down and shown my office which consisted of a table and a chair and a typewriter and a filing cabinet in a corner of the housekeeper's room. That was my establishment. It wasn't ideal from the point of view of privacy because it was difficult to interview people. But it had its advantages because the housekeeper was the hub of a lot of activity. Nurses and domestic staff came in and out and so on. She was a pleasant woman and she was able to provide a bit of orientation for me and I learnt quite a bit from her about the hospital. And I had a mate, so to speak. I had been told that it was nice to have a social worker. So I sat down there and waited. And I sat there and waited for about four weeks and did not have a referral. I decided that I would have to do something about this: I went on her rounds with the housekeeper."

From this contact, nurses started to refer, and patients started to refer themselves in big droves. When she wrote letters, she would check out the details with the medical staff and, in time, they also became active and began to refer cases.

After some years, Barbara Franck managed to get a better office. It was a room that had been done up for the then matron, Matron Kunoth. She had never used it and did not intend to use it. There was a great hassle about this room, for Dr. Birch's cast-off carpet had been laid in it for the Matron and Barbara's status did not warrant a carpet. It was months before the obstacles were overcome and she was able to move in.

As social worker, Barbara was responsible to the Superintendent and had free access to him. When she had gone to Parkside, Dr. Birch had said that she was to go to him if there were anything that she was not sure of. This was most satisfactory for, being so isolated from all the clerical, staff who were up front, and in fact from everybody else, she would just go up and ask him things. He was very approachable and supportive, and provided her with the anchor that she needed.

It was interesting to find, she said, when she got to know the medical staff, that they all found that they suffered from the same stigma as the patients. Their colleagues felt about them the same way as the community felt about patients. Working away from the city, being unable to go to lunch together and that sort of thing, she found she lost touch with colleagues, and was surprised to become aware of the hostility that other social workers had towards the hospital.

In her work she found that she was expected to photograph a whole backlog of patients who had not been photographed for years. The photos were attached to casenotes for identification purposes. She did not quite see this as social work. She also was given "funny little clerical jobs", sent down from the front office, which she could not show a good enough reason for not doing. They did also serve to give her an insight into the running of the place. Eventually, she became too busy and was able to demonstrate that her time could be better spent.

The patients had visitors on only two afternoons a week. That was their contact with the outside world. That was all they had. Very few went out on trial leave or weekend leave. They had a picture show once a fortnight, and two bus drives a fortnight - one for the male side and one for the women's side. They had some church services and a few church visitors. Some of them were of the "lady bountiful" variety, coming around handing out sweets. Some saw special patients, but there were not very many of them. Patients were shut up in their wards at 6 o'clock at night and let out at seven next morning. So it seemed to Barbara that they had to open up some communication between the hospital and the outside world.

"We were just so isolated. Though I had some individual patients I had to do things for, I spent a lot of time trying to do something about this isolation. I spent a lot of time with ethnic groups, Slavs, Italians, a biggish group of Polish people and so forth, who never saw anybody. It seemed to me that the only thing was to get in touch with ethnic priests and groups and to encourage them to come. They were very good and visited and brought foreign language newspapers and got themselves organized. They brought something into the lives of the patients because they could at least speak their language. I got in touch with various Consuls and they were helpful. This, too, proved to be handy later on when we had to deport people, or repatriate them, back to their own countries."

Barbara Franck set out to do something for the small number of patients who were being discharged or at least being given trial leave. She went through the newspapers and picked out a few boarding houses and persuaded four or five of them to take some ex-patients. She said: "Just try a patient. If it doesn't work they can always come back to the hospital. But just give one a go". Those managers who did take patients found that they were, by and large, a lot less trouble than other people who were more likely to go out at night and come home late. They were easy to look after. As a result of this experience she was able to encourage some managers, as it were, to specialize, and this group formed the nucleus of what became the psychiatric rehabilitation hostels.

Much of what has been described occurred before the advent of the psychotropic drugs. Largactil was introduced in about 1957, five years after she started at Parkside Mental Hospital. She recalled: "The results were absolutely magical. Literally hundreds of patients got better." But the isolation remained. Another way she attacked this problem was to start taking social work students from the University for their practical work training. By and large they were scared and did not want to come; but, once they had been, most of them found it rewarding. As a result, the hospital gained quite a reputation with the University as a good place to train, and some students later took positions on the staff for a time. There was little difficulty in getting students, and, as they were always on the move during training with various agencies and talked around, they became a good public relations exercise. She was, in fact, breaking down the walls well before Dr. Bill Cramond came.

She recalled how scared people were of the hospital. When she first started, people would ring up and complain that there had been a "funny noise" the night before and ask "has somebody got out?" Any odd noise in the area was always attributed to the patients.

As a way to marshal support, Mrs. Franck did a census of the patients to ascertain what Church groups were represented. She found that the Anglicans were the biggest group. So they were targeted!

"I went to the Dean and asked whether his Church could help us with visits or something. He said: 'Well, if your Superintendent could write to us and request it?'. So she went to Dr. Birch, told him what she had done and asked him for the letter. Dr. Birch, however, retorted: 'If he can't do it without being asked, I am not writing any letter'. So she found herself stuck between two Scottish gentlemen who were quite stubborn and not going to move an inch."

What to do next! She went and saw Joy MacLennan, the Church of England social worker. She produced the President of the Mothers' Union, who was a forceful, forthright, active and intelligent lady, and had some hundred women under her auspices. She got them going; got them organised to provide the women patients, Barbara thought, with a party a fortnight in the hall at the hospital. More than this, this active woman went around all the churches in the metropolitan area, and some outside the metropolitan area, and told them of the needs of the patients for visiting, and that she expected them all to visit once. If they didn't like it they need not go again, but they had to go once. This was so that they would not turn up

their noses before they got there. These women turned out to be wonderful: they visited regularly, brought food and party materials; they played games. The patients did respond. They liked it.

Some parishes would adopt individual patients. If a patient was ready to go out on trial leave, they would accompany them on an outing for the day or take them home for the afternoon. Even to start talking to them in the hospital was important because it was very difficult even to get patients to talk, let alone initiate a conversation.

When the drugs came there was this mass of Mothers' Union members who were milling about the hospital and saw it all happen. They were able to go home after a party and say that "Mrs. So-and-so who hadn't talked for years spoke to them today". They could see the transformation and they could see the potential in the new drugs. Their observations were very important. "So, we owe them a debt".

"We had various other people come. Ruth Bright was such a one. She was a musician, a married woman who wanted to do something to occupy her time and was interested in music therapy. I set her up in Female E ward, the Admission Ward. She was very depressed to start with because there she was singing away and she did not think any of the patients were joining in. It made her feel better when the nurses told her that they were in fact singing. She just could not hear them because they had remained in their chairs around the walls of this large, slate-floored ward. She had expected them to cluster around the piano as normal people usually do. That cheered her on and she started a choir in one of the female back wards. Having seen changes in the Admission Ward patients, she decided to try in one of the chronic wards. She set up the choir and one or two of the patients who had been mute for years started to sing. They still didn't speak but they sang in the choir. Things were going very well; but she got pregnant and her husband was moved to Sydney and that was the end of music therapy. It was so difficult to replace her. She has since become very famous in Sydney. She is very well known, has written two books on Music Therapy and is a specialist. But she got her start at Parkside and that is something.

"Then we had John Morley. This had nothing to do with me. He was private enterprise, so to speak. He was an artist who did art therapy in the back wards on a Sunday morning. His target was the profoundly retarded. I don't know how he motivated them or got things started but those people, who had no language and were doubly incontinent and had problems in relating to people, produced the most beautiful art on the glass windows with brushes and coloured paints. Morley filmed a lot of this and the film is/was in the Canberra National Library. It was called 'Every Sunday Morning'."

She recalled further:

"One of the other groups we got in was the Passionist Fathers from the monastery at Glen Osmond. They came down and got involved with Z Ward and some of back male wards. They were from a seminary for training priests. For several years, their students were sent down on weekly visits so that they would have some background in psychiatry when they went out into parishes. They were a very nice bunch of men. That was a very good happening.

"Then, we had Mr. Rogers, the retired Methodist parson. The poor man came along one day, put his head in the office and said 'was there anything he could do?'. That was the end of him for about five years. He did a wonderful job; he did what the Mothers Union had done but on a grand scale, and not just for women. He had two drives a week for everybody. They went all over the place, out round the countryside, sometimes out to a country parish for lunch and back again. The hospital drives had been purely in the bus with no contact with people. The Church ones were different: they went out to a parish and got out of the bus and met the people and had a meal together and made contact.

"We had the first mixed party for patients through the Methodists. The hospital was divided down the middle, the women on one side and the men on the other and never the twain did meet. At the picture shows it was the same; at church services it was the same: no one crossed the centre line. We thought this was a bit silly, if they were to behave as normal people when they got out of hospital. I tried various ways but could never get permission to have a mixed party. So, finally Mr.

Rogers said: 'I know what we'll do; we'll have a prayer meeting!' So, I went up to the Boss and said: 'Please, could we have a prayer meeting for men and women', and that was all right. So, once we got the prayer meetings off the ground, the women brought tea and buns and we had a pianist and there was dancing, and it was O.K. It was just a matter of breaking down that prejudice, the anxiety I suppose."

Barbara recalled that it was often easier to get ideas than to make them work. The doctors wanted the patients to be able to stay up until 9 o'clock instead of being put into their beds at six or being locked in at six. They had got permission for this move. However, this was before television and the patients would not stay up: "They were like hens and all went to bed at six and that was it". Dr. Mickleburgh⁶ came down and said: "Can't you do something; because if we don't get it working we shall lose the privilege". So the Methodists were prodded into action again. They got groups to come out at night and play games and play cards and that sort of thing. Then the Church of England came out - the Men's Society, she thought - and they started doing things at night. This was to be a temporary measure until the patients learnt to entertain themselves; it went on a lot longer than was anticipated. The patients did have to learn to do it for themselves; they did not have television then to entertain them. It was necessary to keep a movement going, otherwise it was easy for things to slip backwards.

"In 1957, when largactil became available, the changes were amazing. The canvas clothing, the kickers, the straight-jackets, all the restraints, were dropped within a fortnight in the wards where the drug was introduced. And people who had not been able to string two rational words together in my five years of knowing them just suddenly got better! So we were confronted with all these people who needed to get out of hospital. I remember Dr. Birch saying: 'There is a tide in the affairs of men, and if we don't do something they'll get sick again.' But, you see, they had no family left, no friends left, they had no contacts. And even those that did, it was difficult for them to take a patient home after thirty years; it was difficult on both sides. That was when the use of boarding houses was stepped up.

"By that time we had a psychologist. Pat Loftus⁷ had come. We had to get patients used to the idea of leaving, because a lot of them did not want to go, naturally enough for they had been there for years. So we started a discharge group between us. We had about eight patients. We made them come down on their own from their wards to Cleland House, which had been opened by then. The nursing staff were scared that they would all rush out the front gate. But they didn't have a rush left. They used just to sit down there. It was agonizing because we were trying not to talk ourselves so as to provoke them into talking by our silence. But it didn't work. They had been used to sitting round and not talking for years and they didn't mind. It was Pat and I who got anxious!

"One of the patients was talking about her hallucinations and delusions and things one day and we said: 'Do they worry you?' and she said: 'Oh no. They're companionable.' So, they used them for company and they sat round there, hallucinating away in the group. It was very hard work. It was a very great thrill one day when one of them addressed another across the room. Instead of just answering our questions they had started to talk to each other. We got lots of patients resocialized through that group. Then they would plan an outing into town, how to catch a bus, how to use a telephone, how to post a letter. These things were absolutely vital for most of them if they were going to survive out there. There was one man who had been in hospital for fifty years. The medical officer said to him one day: 'Would you like to leave, Mr. So-and-so?' 'Oh yes', he said, 'Thank you', and he packed his bag and he went and that was it. We never heard from him again. He was quite alright. He had just been sitting there for goodness knows how long and no one had ever thought to ask him if he would like to go.

"There was another wonderful story. The wards were reclassified after Dr. Cramond came and we started moving people around and reclassifying them. They moved one man out of a ward and into another and he went right off. He had been pretty right for a long time and he became as psychotic as they come. It was some time before we found out that he had been running an SP bookies business in the ward where he had been; and now they had moved him and he had left all his goodies behind. He hadn't been able to bank his proceeds. So this had set him off again; and

spoilt his business, too, once everybody was a wake-up. He had been going along happily for years. It upset some of the other patients who had been betting quite happily with him. Still, it was a good thing really to find that some normal activities had been going on that we did not know about."

By 23rd May, 1958, the inpatient numbers had gone up to 1,769 patients, the highest number in hospital in any one day since the Hospital had opened in 1870. By that time, too, the outpatients had started increasing. Discharged patients were reporting back and so on, and "things were really popping".

Another thing Barbara recalled they were able to change related to the Commonwealth Department of Social Services. The Department had been paying the wives of male patients a Widows Pension to live on while the men were in hospital. When a husband was able to go out on week-end leave, the Department had to be notified that the patient had gone home on the Friday night and promptly stopped the Widows Pension. When the man was re-admitted on the Monday, the whole process had to be set in motion again. But the wives would be stranded because it might be a fortnight before they would get their next pension cheque. They would have to go to the State Relief Department for help. Some were not able or were not willing to take people out under those circumstances. It was pretty devastating to have to change from receiving a regular pension to lining up in a relief queue to get the dole just because you had taken your husband home for the week-end. It was bad enough being on a "widow's pension". She had had women come to her in tears when informed of the fact: "Is he going to die?" She managed to get this changed.

Dr. Cramond came in 1961. That was when there was the big reclassification of wards. Prior to that all the small mentally retarded children had been kept in one of the back wards with chronic female patients. This was badly misunderstood by the outside world. People used to say 'how dreadful!'. But, in fact, it was good for all concerned: the women had somebody to mother and love and the children had all the affection they could soak up from the women. They had a mother-child relationship. When the elderly women were shifted out of the ward, a lot of crises developed. Children who had grown up with a surrogate mother, who were fourteen years old or so, did not see her again. They just had to get used to it and that was that. It was something that was misunderstood by a lot of outside social workers who felt children should not be

exposed to "psychotic" women; but the children were so slow in developing and it took so much longer for them to reach their milestones that they needed the extended mothering.

(I commented that this had happened spontaneously in Parkside, whereas Dr. Eric Cunningham Dax⁹, at Kew Cottages in Victoria, following the work of John Bowlby¹⁰ on "Maternal Deprivation", had actually brought chronic, psychotic women into the children's wards to provide the mothering.)

Barbara recalled one male child, aged 8 or 9, who, on admission, was thought to be too big to go to the children's ward and was put in Male K with older retarded men. He at once curled up in the foetal position and stayed like that for weeks and would not eat or anything. So she went off to the home to get some history about him and she found that he was one of five children and the other four were all girls. He was used to a female establishment; he was terrified really. She came back and told the doctor and they moved him to the women's ward. He uncurled, started to eat and to function again. "He just could not cope with all the male surroundings".

In 1962, ten years after she had started at the Hospital, Cleland House was declared a Receiving Ward. For some months before the Commonwealth Department of Social Services reversed its decision, things became pretty hectic as patients applied for Sickness Benefits. She was still the only social worker. She had no receptionist and no clerical help. She had the use of a typist up in the typing pool, which was miles away from her office. Eventually, the typist was allowed to move down to a cubby-hole next to the social work office and, later, was even given a telephone so that she could assist by taking messages and handle some of the calls.

Barbara Franck discussed at some length the difficulties she had as a social worker at Parkside Mental Hospital, or Glenside Hospital as it became. These difficulties were related to the attitude of the male clerical and other administrative staff. She thought it was partly because she was a woman (feminism had not reared its head in those days) and partly because she could not easily be categorised. They did not know where to put a social worker. She was not a doctor or a little nurse, and she was not a typist; so what was she? What do she actually do? It was actually very hard to demonstrate. She was sort of invisible in

this way. She was also invisible in the physical set-up, because they did not see her very much up there in administration. She was out in the wards, doing a home visit or whatever, but not in the office very much. It represented the sheer bureaucratic rigidity, like the problem of the carpet. She can remember hearing them say: "Who does she think she is? She wants a typist!"

By 1964, even though Dr. Cramond had managed to introduce a cadet scheme for social work students that guaranteed a supply of replacements coming through, it was still difficult to get social workers to come out and work at the Hospital. That was when Dr. Cramond decided to start the Mental Health Visitors course, and provide in-service training, on social work lines, for suitable senior nursing staff and other people who might have relevant experience and languages other than English and so on. One day he handed her this programme and said "Run that! Great faith in us all, he had."

Between 1964 and 1973, five Mental Health Visitor courses were run. These were organised and supervised by Mrs. Franck who had been promoted to senior social worker. In 1967, when the "chief job" was created, she applied and was appointed Chief Social Worker. In 1975, the mental health visitor course was taken over by the South Australian Institute of Technology Social Work Department and became part of the Associate Diploma. It thus became possible for many of the Mental Health Visitors to go on to do social work. These courses and the work of the Mental Health Visitors have been discussed in detail in two articles elsewhere¹², one of which created world-wide interest.

To administer the service more easily, the Chief Social Worker moved to Headquarters on East Terrace, Adelaide, in 1969, leaving a staff at Glenside of 5 social workers and 12 mental health visitors. By 1974, to keep pace with the overall expansion of the Mental Health Services, there were eighty in the social work department overall, that is, social workers and mental health visitors. They were a bit more comfortable, too, as more office space became available with the movement of more patients into the community. Mental Health Visitors were seconded full-time to The Queen Elizabeth Hospital, and to country clinics, attached to the district hospitals, on a sessional basis: to Mount Gambier and Loxton from Glenside, and to Pt. Augusta from Hillcrest. A Handbook of Social Resources of the Riverland was prepared at Headquarters, after consultation and collaboration with Riverland workers. An edition of some

200 copies was printed and distributed through the area. It was a success though nobody thought it would be.

Work with the Hostels took a good deal of the Chief Social Worker's time. With the Community Psychiatrist (Dr. W.E. Mickleburgh), the chief government health inspector, and the mental health visitor responsible for supervising the hostels, she drafted a set of regulations for the control of standards by managers. That took some months to prepare and rather longer to get through Parliament. Also, a Handbook for Managers was produced which had to be updated fairly frequently. A training course for Managers was established and she helped Hostel Managers to form their own Association and to organise regular meetings. In addition, there was the annual inspection of hostels, the assessment of prospective managers, and the renewal of licences every year.

The establishment of a Social Studies Students' Unit within the Mental Health Services was approved by the Public Service Board. This was the first in South Australia, and the Board was very enthusiastic about it. Mrs. Dorothy Pryce¹³ was appointed to take charge. Student prejudice had been overcome, psychiatry was becoming popular, and the increasing number of students benefited from the structured supervision they received in that sort of unit. It worked well.

In looking back over her work at Parkside Mental (Glenside) Hospital and the Mental Health Services, Mrs. Barbara Auld summarised her experience as follows:

"Social work has a lot of facets and different approaches. It depends on the needs to be focussed on at the time. There was no point in going in and trying to do social case work in Parkside with sixteen hundred patients. To concentrate on that and ignore all the other problems would have been to achieve nothing really. In 1952, the patients had been found to be isolated and largely ignored by the community. The Institution itself was sick. Due to a number of circumstances it had stagnated. Over the years the isolation was broken down and the ground prepared for the advent of the new treatments when they came and the vast changes that then took place. Social workers could then play their part to help that process along."

Regarding Dr. Hugh Birch, she said:

"A lot of people were scared stiff of him. I think he was a very shy man; he had a lot of trouble relating to people. I think he trusted me for I used just to go in and out. I'd knock on his door and he would ask me to come in. He knew what I was doing because I was always asking him about things. He'd ask me to do all sorts of things for him that he thought I would be O.K. at. For example, I would go and see some people down at the gaol and that sort of thing. He was unable to get about easily and he would ask me to do things around the hospital that he wanted checked. I liked him and I found him sympathetic to a degree. He was a very compassionate man. For patients, he was really there for them. Anything that was not in their interests that he could see and that he could do something about, he did. He belonged to a certain period. You accept the norms of the period; I did when I went there first, too. You look back and say 'Goodness me!' But that was how things were. You do something to change them, but — I guess he did things, but he was limited by finance, and the War caught him and he had all the plans for new wards and buildings that he couldn't use. Then we were laden with all those children from Minda who shouldn't have been there. He had taken them during the War to help out and then they wouldn't have them back."

"Dr. Cramond was great. He was a different kind of person from Dr. Birch. He expected a lot. He knew what social workers were for, whereas Dr. Birch did not know the whole range. Cramond knew how to use them. But then he had come from a different background. He had also come when the time was right, when politically things were on the move.¹¹ Though setting up the course of training for Mental Health Visitors was a tremendous load, anything that I wanted I got. I had only to say that something was a good idea and it was approved. He trusted me to be sensible and not to ask for things that were unrealistic. I found he was very good to work with. I liked him. But, then, he had come from a different background again. He came when the time was right; when things were on the move and it was our turn for Government money. We had a big fling for about two years, I think, and then it dried up and the Education Department, I think, was next on the list.

"Mick" (Dr. W.E.) Mickleburgh⁶ was an ideas man. He was good. He was the power behind getting the patients sitting up at night, getting the wards open. Then again, he had arrived from England when there were changes in sight. He was very supportive. He wanted me in on everything though it was not always possible. That caused a bit of strife for I think he thought I should be for his personal use. This was when he was going round inspecting all these strange boarding houses to which discharged patients had drifted and wanted me to come. I got around this one by getting a couple of the new mental health visitors trained by sending them around with him and this was a better idea really. He was very community minded. We had a lot of clashes because of the things he wanted to do or wanted me to do. But basically, we got on very well."

(iv)

Harry Milton Southwood, unlike Birch, Dibden and Cramond, came into psychiatry more by design than by accident. Unlike them, too, he suffered from no physical impediment. Perhaps, as with Dibden and Cramond, the combined circumstances of the Great Depression and World War II may have facilitated his decision, but they certainly did not initiate it. Southwood graduated in medicine in 1932 and did not go to Enfield Receiving House, his first placement in a psychiatric institution, until 1939. But his interest in psychology and psycho-analysis preceded even his entry into the medical course.

He first heard of Freud when he was 15 or 16 from reading A.S. Neil, a Scottish schoolteacher who used to run a progressive school in England. Neil was interested in modern ways of education and the theory of education. He started all sorts of unorthodox teaching. He had written "The Dominee's Log" and others; very light, very easy-to-read books about his experiences, and he had talked about Freud and the psychoanalytic theories of behaviour.

"I used to go to the Public Library to read books on English literature or whatever, while studying for the leaving or leaving honours examinations, and I came upon Freud. In those days,

Freud's books were kept under lock and key. My interests went right back to then. But that wasn't why I took up medicine".

He took up medicine because people said: "Oh! You'd better be a doctor like your brother". And, without even thinking about it, he sort of went along. He thinks he would have been a surgeon if he had had the opportunity. Instead, he drifted into general practice. His brother, Ray Southwood, had had a nuclear sort of general practice in the west end of Adelaide, but had specialized as a physician and later moved into Public Health. Dr. Charlie Savage had taken over the general practice. Then he left to specialize in tuberculosis. That left the practice vacant and it was offered to Southwood. He started up in general practice in "The Depression", in the early 30's. The west end of Adelaide was a most depressed area. He had little work and plenty of time to spare. He started to read books about the treatment of neurosis, such as Ross's "The Common Neuroses".¹⁴

"I started to see these people. Of course, they didn't have any money and I had plenty of time. So, I'd get someone to come round and see me in a spare afternoon. I'd spend an hour or so; I didn't go by the clock seeing as I wasn't charging them. If I did, I would charge them only the ordinary consultation fee of 7 shillings and 6 pence or thereabouts. It wasn't special treatment - simply something a la Ross. I was simply taking a more detailed history to try to understand just how it was they had got into the mess they were in. I had the idea that if we could understand all about it we could find a better way of coping with whatever the problem was. It was all on a very superficial level. When I went to Enfield [Receiving House] I again had plenty of time. When I found an interesting case, I used to get him into the office and go into the history in the same way. Often I spent hours talking to schizophrenics who were sufficiently voluble to hold forth about their delusions. I talked to paranoid people, going into all the intricacies of their delusions and hallucinations. My methods grew simply by practice, by talking to people".

From the end of 1938, Dr. Southwood, in his small general practice in the west end of Adelaide, spent his spare time doing various post-graduate studies. He obtained a B.Sc.; not because he wanted a B.Sc. particularly but because he wanted to increase his psychological knowledge. At that time there was a course

at the University of Adelaide, a B.Sc. course in psychology and philosophy, run by the Professor of Philosophy, McKellar Stewart. Between 1939 and 1944, he also qualified for the M.R.A.C.P. (Member of the Royal Australasian College of Physicians) and then an M.D. in Neurology and Psychiatry.

Until Southwood arrived in January, 1939, the Enfield Receiving House was in charge of a Dr. Rogers, "Daddy Rogers" as he was known to the students. He lectured on Forensic Medicine. Dr. Geoff. Howard was Deputy Superintendent of both Northfield [Mental Hospital] and Enfield [Receiving House]. Southwood had been appointed Medical Officer, half time, from 9 to 12 each day. However, around the end of August, 1939, just before the War broke out, it was decided that Geoff Howard should work full time at Northfield and Southwood was asked to become full time at Enfield. The War having broken out before things were fixed up, he was allowed to continue his private practice, which was very small anyhow, provided he worked from 9 to 5 at Enfield. This meant that he often did two or three visits in the morning before he went to Enfield and he held an evening surgery at night from 6 pm on.

At that time, Enfield nominally had 35 male and 35 female beds, on each side. The hospital population consisted mainly of those who were sufficiently well-behaved, whose psychotic condition was sufficiently mild to enable them to be nursed without undue restraint. Though they had such things as straight-jackets and padded rooms, they were rarely used. Anyone who was the least bit obstreperous, noisy, uncontrollable, or aggressive and so on, was promptly certified and sent to Parkside. There were a number of mild senile demented; but the great majority were melancholics, now called depressives. The demented were not kept for long. If they couldn't be found private accommodation, they were sent off to Parkside. Melancholics were kept there for quite a long time. The law, at that time, was that they were committed to Enfield for up to two months; but this time could be extended by the medical superintendent for a further four months. After this they could not stay any longer unless they were re-certified. So the situation was that about three quarters of the patients on each side were melancholic and about one quarter were demented.

The main duty of the nurses and the attendants every morning was to get the melancholics up and about. There were people there who had to be tube-fed, force-fed, or bathed and dressed. Then cardiazol came to be used.

"Geoff Howard brought it over and we tried it somewhat cautiously on the melancholics. In a very short time they started to eat quite enthusiastically and put on weight (some even got over-fat) and to become active. Many of the former main nursing duties vanished. So, not only did psychiatry change, the atmosphere of the hospital changed. Instead of a sort of nursing home for people who had to be pushed around in wheelchairs and led to the bathroom and toilet and all the rest of it, it became quite an active place. We started to think of occupational therapy".

A bowling green was put down by the attendants, with the help of patients, for the men. Later they built a tennis court. One of the female nurses was interested in weaving and that sort of thing and occupational therapy was started for the women patients. The whole atmosphere changed. Then electricity took over from cardiazol. Southwood recalled:

"Dr. Birch built the first electric shock machine, I believe. Later on, I made one. Mine was originally made out of a gramophone. I used the motor which normally runs at 78 cycles per second. I had the governor altered - put extra weights on the governor - so that it ran at 60 revolutions per second. That made it a nice round number, one rotation per second. Each time it rotated it flicked a switch for one tenth of a second. So you simply set the thing going and every second, for one tenth of a second, the patient got a shock. This was a much more sensible scheme in my opinion, because it didn't require any pre-setting. With "Hughy" Birch's machine, you had to guess how much the patient needed. With my machine, we found the shocks accumulated nicely and after 6, 7, or 8 the patient started to go into his fit, and so you switched off the machine and attended to the patient".

Insulin was not used a great deal at Enfield. However, one treatment that gave pleasing results was the malarial treatment of G.P.I.¹⁵ It was already being given at Parkside, but was started at Enfield in Southwood's time. The malarial blood was obtained from Melbourne, where they had the treatment in the mental hospitals there. A message was sent to Melbourne and the blood would be flown over. When

injected into the patient, some days later, he would start to have a rise in temperature with rigors every other day. Patients were allowed to have about ten rigors and then were given quinine. This stopped the fever in two to three days. Dramatic improvement in the mental symptoms usually occurred.

Southwood was at Enfield from 1939 till 1946. He did not particularly want to leave. His resignation was precipitated by departmental red tape. After five years he had applied for the old Section 21 leave. This was six months leave on full pay.¹⁶ However, it was argued departmentally that this leave was only for medical staff that lived on the premises of a mental hospital and he did not live on the premises. His argument was that it was not his fault that he did not live on the premises, as no house was provided in which he could live. He claimed that he should not therefore be penalised. The outcome was that he was granted six months on half pay. He took a month's annual leave and a month without pay and went off to Melbourne for eight months.

During this time in Melbourne, Southwood started his analysts with Dr. Clara Geroe. He also did some work for Dr. Reg Ellery (he gave his electro-convulsive therapy treatments for him) and this helped to keep the wolf from the door. When he returned to Adelaide, the Department informed him that he could no longer continue his private practice as the War was over. He did not want to do this as his income from the job at Enfield alone would not have permitted him to live very well. He also felt pretty certain that he could do better in private practice. After all, he had an M.R.A.C.P. and an M.D. and so felt he could justifiably call himself a specialist. He gave up the hospital towards the end of 1946. In due course, Southwood was appointed lecturer in Psychological Medicine at the University of Adelaide, succeeding Dr. H.M. Birch.

Southwood's interest in psychoanalytic training was stimulated in about 1939 or so when an article about psychoanalysis appeared in the Medical Journal of Australia, written by Dr. Roy Winn. A soldier who had lost a leg in the first World War, Dr. Winn had had some analysis in England and come back to Sydney as the first psychoanalyst in Australia. After the article appeared, Southwood wrote to Winn saying he was interested in psychoanalysis. Winn replied informing him that Clara Geroe had recently arrived in

Melbourne. This must have been about 1944. So Southwood wrote to her, and never had a word in reply. About a year later, he wrote again, and she rang him up.

"This seemed to be her system. She did not answer letters; but if you wrote two or three times, she would think you meant business. Anyhow, we eventually got into communication and, as I had this leave coming up, I arranged to go to Melbourne and start my analysis with her.

"Once I'd left Enfield, I used to go over to Melbourne, periodically, every two or three months or so, for 4 days or a week, and continue the sort of analytic talks. In those days, analysis was not very well organised as to the system of training. The centre in Australia was, as it were, an unofficial branch of the British [Psychoanalytical] Society. But it was just after the War and everything was chaotic. There were four of us in training, I, Frank Graham, Rose Rothfield and Phillips (who subsequently died)".

While Southwood was in Melbourne, he spent a lot of time reading analysis. He had the half-time job doing E.C.T. for Dr. Reg Ellery. Every afternoon he read analysis beside going to his analytic sessions and so on. He really did a lot of work.

As regards supervision, he described how he would analyse someone as best he could in Adelaide and take his notes across to Dr. Geroe every month or so and have long talks, sometimes all afternoon or a whole evening, discussing all that had happened, and what he should have done and all the rest of it. This went on between 1946 and 1953. Eventually he thought he had written up enough work, so with a certain amount of pressure from him, and reluctance from her, Dr. Geroe eventually recommended him for Associate Membership of the British Psychoanalytical Society. Southwood contended he had probably had as good a training as anyone else, though it was a long, drawn-out affair. In any one year, he did not have very much analytical work. But he did spend over 8 years on it.

Southwood was the first in Australia to be admitted to Associate Membership, Frank Graham following 2-3 months later. He started to practise psychoanalysis in Adelaide, and was the only psychoanalyst there for a long while. By 1958, he had gone to England, read a paper, and become a Full Member of the British

Society. It was after this that he was permitted to train others. He started with three people, Dr. Jack Earl, Dr. Clive Kneebone and Dr. Bob Gillen. They all eventually became associate members of the International Psychoanalytical Society, because, by this time, someone in England had decided that it was not really proper to have a branch out in Australia. By 1973, an autonomous Australian Psychoanalytical Society had been formed; there were 28 members by the end of 1979. The Adelaide Institute of Psychoanalysis was formed in 1979. There was an Institute in both Melbourne and Sydney; the three Institutes made up the Society. In due course, it was hoped to have a complete training programme established in Adelaide. But, at that time, students were having their analyses with Southwood in Adelaide. but having to go to Melbourne, and sometimes to Sydney, for seminars and lectures. To begin with, as the only one available, Geroe had given her students their analysis, their supervision, seminars, everything. But, by 1979, the analyst did not take any part in the training. He (or she) simply analysed, and others did the rest.

After he left Enfield, Southwood practised General Psychiatry as well as analysis. He could not afford to restrict himself to psychoanalysis. Asked if he had ever felt that there was any incompatibility between psychoanalysis and physical methods of treatment, Southwood replied that there would have been if he had been giving such treatment to neurotics. His practice, in those days, was to give E.C.T. to acute schizophrenics and to melancholics; and psychotherapy to neurotics. He admitted Dr. Geroe and some of his colleagues were not too happy about his giving E.C.T. to a patient. He would argue: "Well look, he's psychotic, and I find this makes him better". The fact that E.C.T. worked was proof in his eyes.

Southwood said that, in private hospitals in the early days, he would give E.C.T. without the consent of the patient. He never felt that he was doing wrong. The patient might protest: "Look, there's no use doing anything. It's hopeless. I'm doomed to death. You're wasting your time treating me, doctor", and so on. And he would say: "Oh, what nonsense". And he would give her E.C.T. and she got better. It was not legally required and he did not ask for the consent of relatives. Often the husband or wife was only too glad to say: "For goodness sake, do what you can, doctor; whatever you think best".

In reviewing his early work in the Mental Health Services, Southwood said:

"If I was forced to work back in a hospital, the first thing I'd do with a new patient would be to do nothing, to do as little as possible for the first two or three days. Try and talk to them and see how they respond to the ordinary situation of being in bed, and so on, rather than give them a tranquillizer straight away in order to do something. I think it's silly even to put a person in a group until you know what is wrong with them".

In 1946, the year Harry Southwood left Enfield Receiving House to enter private practice, Bill Salter was appointed Deputy Superintendent of Northfield Mental Hospital.

(v)

William Fulton Salter graduated in 1936. Like Southwood he was healthy and physically able. But he, unlike Southwood, got into psychiatry by a trick of fate. When he graduated he did not have much idea what he wanted to do. For a while, he did some locums and cast around for some sort of general practice he could get into. He unsuccessfully applied for a job in Queensland. Then, while on holiday in Victoria, he received a telegram from Harold Brown, of Brown and Pearce, agents, asking him to do a three month's locum at Parkside Mental Hospital. Salter was not very impressed with the idea of working at Parkside for three months. However, he decided that it would give him a breathing space to look around a bit further before he committed himself to anything, and accepted the job.

He started work as a medical officer doing a round from 9am till 11am. As Salter put it:

"Then your work was supposed to be done. If it wasn't, then someone wanted to know the reason why. You walked through the wards and saw anybody that needed it. In the hospital ward you had a bit to do, but otherwise it was just a matter of looking at the patients and making sure

they weren't dying on their feet, or doing any medical thing that was required. Not knowing anything about psychiatry, there was very little to be done".

However, after a month, Salter began to feel the fascination of the mind and its vagaries. In spite of the fact that treatment was largely custodial and that almost all the patients were committed to hospital by double certificate, he began to experience the challenge of trying to find out what went wrong with the mind, why people became mentally sick and what could be done. Anyhow, after the three months he stayed on. Physical methods of treatment were just becoming available. The outstanding one was convulsive treatment induced by the injection of cardiazol. He gave "hundreds" of the cardiazol treatments and began to see some patients get better. He admitted that they did not know what they were doing in those days, because the definitive use of convulsive treatment for melancholia had not been established. Insulin coma had also come into vogue and he became involved in that too.

Salter emphasised the overall importance of these treatments, because not only did people get better, the medical and nursing staff were stimulated by the fact that they could do something to make people better. This heralded a new era in psychiatry and everyone was involved in it, and became keen to try and improve it. He recalled the great pleasure of being able to spend the afternoon playing tennis with one of these patients who had responded to the treatment. As he put it: "Because I was a very keen tennis player, combining business with pleasure in this particular way suited me very well".

Other treatments were referred to. He remembered using continuous narcosis with "somnifaine", a mixture of barbiturates, that with the right dose kept the patient just out of consciousness, but very easily aroused for feeding and toileting and so on. The main sedative was paraldehyde, but newer barbiturates were coming on to the market. Then came electro-convulsive treatment. Salter recalls Hugh Birch making the first "shock machine" in South Australia. He said: "He was very good at doing things like that, but he hated using it. So after using it once he handed it over to me, and I had a tremendous time".

I can just imagine what the Scientologists would say to a statement like this. They, of course, were not in the mental hospitals in those days. They were not there to see the dramatic improvement in patients as a

result of "shock treatment". They were not there to witness the hope that this treatment inspired nor the change in the morale of medical and nursing staff that occurred as a result.

In 1943, Salter left Parkside Mental Hospital to go into the Army for six months, to relieve me at 105 Adelaide Military Hospital, Daws Road, when I was boarded out on medical grounds. He looked after the psychiatric ward until Alan Stoller came and took over the clinic. He returned to Parkside for a while until he went in as a permanent medical officer "with no knowledge of what medical officers did in the Army at all". He was sent to a convalescent depot at Strathalbyn, which later moved into the Northern Territory. Salter said:

"I had a tremendous time not doing any medicine at all that I can remember. Arthur Welch was the Commanding Officer. It was a gay life: we did all sorts of things like building huts and supervising the transfer of material from place to place. In fact, I was in charge of the advance party that went up to the Northern Territory. If it hadn't been for the R.S.M., who was a permanent soldier, I would have been absolutely floundering. But I kept him at my side and he told me how to keep out of trouble".

Salter went from the convalescent depot to a field ambulance, then became medical officer to a battalion. While there, the A.D.M.S. for that area (Colonel Trethowan) heard that he had psychiatric experience and arranged his transfer to the 114 Australian Military Hospital at Goulburn, New South Wales, which was located in the Kenmore Mental Hospital. Dr. Alec Sinclair was in charge of the psychiatric unit. He learnt quite a bit from Sinclair about the theory of mental illness and began to achieve some clarity in his thinking. He said: "They were very pleased with me, no doubt, because after eight months I was sent as Psychiatrist-in-Charge of the psychiatric unit at Hollywood in Perth, Western Australia, where the Army base general hospital was located".

Salter's humility again became evident. He said:

"I didn't know a great deal about what I was doing, but other people knew less so I was on fairly safe ground. (This mirrored my own experience when I was in charge of the psychiatric ward at Daws Road. It gave one great self-confidence). And I learnt a bit by trial and error. I worked

hard there, I must say, trying to find ways of relieving people who had symptoms. Of course, service work was very satisfying, because people did get better; but, whether it was because of or in spite of treatment, it was hard to say. Nevertheless, you did see people getting better, and it was very different from the psychiatry in a State Mental Hospital".

Salter finished up once more in charge of the psychiatric unit at Daws Road Hospital, where he stayed on, at the end of the War, until 1946. When he was demobbed, he went straight into the position of Deputy Superintendent of what was then Northfield Mental Hospital. He was the only medical officer there at the time. There were about 450 patients. In 1950, Salter went to London for postgraduate training and to do the examinations for the Diploma of Psychological Medicine.

By that time there were four on the medical staff. The majority of these doctors were not trained in psychiatry specifically. Two were ex-medical missionaries, two were retired general practitioners. They were very useful to do the hack work while he did the psychiatric work.

The 450 patients at Northfield Mental Hospital were housed in six wards. To get around he "employed the services of a bicycle" which he had for about 15 years. "It was very useful for getting round Northfield, because of the great distances between the wards. You could speed along the covered ways on a bicycle when not too many people were walking up them".

Colin Haynes, who worked for Bill Salter as Acting Lay Superintendent on and off for 3 or 4 years, had a great admiration for him. He recalled an example of Salter's often unorthodox behaviour.

"On the first occasion I went out to Northfield to work, I drove in one morning about half past seven (I used to go to work fairly early in the summer) and here was this apparition galloping across the oval, pyjamas flapping in the wind, and I found out it was the Medical Superintendent. Somebody had rung him urgently and he hopped up from the breakfast table, pyjamas and all, and took off straight across the oval to wherever he was going. That was Bill. He knew every patient in the hospital by their Christian name and they loved him".

Salter admitted that he did not have many nurses then and they were not very well trained. He was the lecturer. He gave 36 lectures over three years, 12 lectures each year. If they passed they were in. They were called "mental nurses" in those days, the term "psychiatric" came later on. They came from all sorts of backgrounds. Some had been working for the local Council; some had been in factories; others came from varied jobs. No qualifications were needed, except a desire to become a nurse.

As at Parkside Mental Hospital, the matron was the boss in those days, though there was a Head Attendant. Almost exclusively, there were male nurses on the male side, and female nurses on the female side. The exception was the Repatriation Ward because the Commonwealth Repatriation Department, which provided the funds for this ward, insisted on having a trained nurse in charge, and the only trained nurses in those days were female. Salter recalled:

"The Life of the patients was terrible then. Most of their spare time was spent in the airing courts, surrounded by 8 feet high cyclone wire fences, which weren't very difficult to scale. But, if anybody got over a fence, there was a 'Please explain' as to how they had got over and why they weren't nabbed in the process. One of the first things the nurses had to learn when they were inducted into their nursing duties was to patrol that fence and make sure that, if anyone tried to get over, they grabbed them by the leg and brought them back. If they did get over, then there was a hue and cry and a trail of people streaking out across the paddock after them. It was a terrible thing to lose a patient. There were only three voluntary patients in the hospital; all the rest were certified".

There were, in retrospect, some amusing incidents. There was the occasion one night when the Head Attendant was going to a bridge party and saw a patient escaping. Hiding his identity, he offered the patient a ride in his car. When the patient got in, he turned round and made for the hospital. But the patient realised what was happening, jumped out of the car, and streaked off across the vacant cow paddocks opposite Bill Salter's house. Let Bill Salter tell the story:

"There were no houses there, nothing, right down to Hampstead Road. So he raced into my place and said 'There's a patient escaped'. The cops and robbers scene was enacted very smartly, with us streaking over the paddock, up and down, putting our heads down so we could get a

glimpse of anything moving against the skyline, looking under logs because it was quite wild country, looking into holes. We were determined to get our man if we possibly could. We must have spent something like two hours; and the joke was that he had gone another way and was home in bed in the hospital while we were doing all this".

Dr. Birch had a great sense of his responsibility to the public. He was very keen that nobody did escape, that they were all accounted for. Patients used to be counted in and out of gates when they worked in the grounds, cutlery was all counted after meals, and all the laundry was counted into and out of the hospital. There was a tremendous counting going on; accounting was a big part of people's work.

"There must have been a feeling that we had a great responsibility to the public, and this had to be discharged by making sure that nothing untoward happened and that no patients got away. I know I used to feel guilty if anybody got away. I was thoroughly indoctrinated in those days. It was many years before we began to see how futile it was to keep these poor beggars just locked up, walking up and down in the airing courts waiting for the next meal and nothing else. It was just a hopeless existence".

Salter remembered wondering why the patients were so different from what he had seen under service conditions in the Army. He assumed that it was a different sort of illness. It took quite a while before he realised that they were depersonalizing and dehumanizing people by the way they were being treated. He paid tribute to the role of Russell Barton's book on "Institutional Neurosis" in awakening him to the fact that they were making zombies of patients by the terribly restrictive way they looked after them. He also thought that his going to England and to the Maudsley Hospital for 10 months helped to change his views. He acknowledged the benefit he derived from working with Denis Leigh. "I got some very useful grounding in psychotherapy. You became very self-conscious about your part in a conversation with a patient and what sort of things motivated you to be interested in the patient". Later, he found this experience very useful when helping the young doctors who were now coming to work in psychiatric hospitals. But more than this, he also saw, by contrast, that Northfield was pretty much in the doldrums as regards modern ideas of treatment, in particular in the matter of input into the patients, instead of just repression, of just holding them down and stopping them from doing things. In the Maudsley Hospital, he believed, there was a

different attitude. Admittedly, they had different sorts of patients, but he got enough of a feeling that the work of a psychiatrist was to put something in to people, to bring something to hie in them, to start new ideas and motivations, and to keep them in contact with each other and the world. This is where he began to think more definitely about it. So when he got back, one of the first things he got stuck into was group therapy. He began to gather patients together in groups and see where it led, and try to interest staff. Gradually, the ideas of getting patients to interact with each other, and to look for any lead for the development of motivation and communication, began to take on with the staff generally.

In 1966, Salter took over from Dr. John Cawte and became Superintendent of Enfield as well as Hillcrest Hospital (as Northfield Mental Hospital was by then called). He recalled that, when they decided to take down the remaining airing court fence, the staff was still quite apprehensive about not having any place in which to confine patients. It required a gradual process of education to deal with their anxieties about what would happen if patients really got out of hand, or decided to run away, or whatever, and then eventually to find that nothing really did happen. This staff anxiety was so similar to that observed at Kingseat Mental Hospital when Bill Cramond set out to bring about change.

Another person whose anxieties had to be alleviated was Dr. Birch. Bill Salter claimed that Dr. Birch was very conservative in his ideas, and the easiest thing to do was to do something and tell him afterwards. He was very cautious about anything new and progressive, possibly wondering whether there might be public disapproval; but, if somebody else took the responsibility and he had the successful experiment presented to him, he would go along with it.

Other members of staff became very keen on innovations about this time. Salter recalled Ron Hardwick, a nurse, who was "out to get hold of anything that would open up the life of the patients". Though quite untrained, he was an innovator by nature. He had a mind that was always looking out for something new and interesting. "I'm not sure whether he started the first printing press that we used to print "Northfield News", as it was then called, later to become "Revelation", but he seemed to have a means of knowing where things were that could be used; and he was excellent at getting people to co-operate in starting something off. Salter felt he got the credit for things that were really Hardwick's ideas. He felt he

got the credit because he had said: "Yes, that'd be a good idea". Industrial Therapy grew out of the same spirit of innovation. Of course, it took time to train people; some of the staff were very reactionary. But they became keen to make it go once they began to see the possibilities.

Salter remembered, too, when they began to think: "Why should we lock all the patients up all the time. What would happen if we unlocked one of the wards and gave the patients a chance to expand their environment and their limits?" So, one morning the doors of one ward were left open and the staff waited to see what would happen. Nothing did. The patients went on as though the place was locked up. One patient was seen to come and stand at the door and look out; he put his head outside but kept his boots well inside the boundary. He just could not get himself to go out. Another patient complained to the Charge Nurse that one of the nurses had really gone crazy and left the door open. Salter said they realised that they had to train the patients to develop new qualities in their minds that had been restricted by years of imprisonment, by worse than imprisonment, in fact. Many of them had absolutely nothing to do. It was a real battle to try and undo this. But then, the wards were gradually opened.

They were pushing ahead with the liberalisation and the reactivation programmes for patients at Northfield Mental Hospital when Bill Cramond came along in 1961. Bill Salter said:

"He suddenly gave it a huge push. He took down all the fences around the airing courts; he took the bars off the windows, and declared that Northfield was going to be an open hospital. And the worst thing of it was that he also said: 'And you're going to be Superintendent', which meant he was going to take his hands off it and leave it to me. I had an awful time for a few months explaining to staff why we'd reversed our policies on so many things; because suddenly many of the policies were blown sky high. Our concepts, that we had been developing or trying to modify, were suddenly modified out of all recognition by this liberal-minded Superintendent from Scotland".

Though Salter gave credit to Hardwick and others for being innovators, there was no doubt that he made it possible for things to happen. But when Alcoholics Anonymous started at Northfield, Salter himself was the initiator. He recalled that it was in about 1953, not long after he came back from the Maudsley Hospital, that he became impressed by these hopeless characters that came into the hospital, toxic

with over-indulgence in alcohol. "You put them into reasonable shape and sent them out, and they repeated their past performance. It seemed such a waste. It used to infuriate me to think that we had to spend all this money and time on somebody who was just going to repeat the same destructive act all over again".

One day Salter heard the film star, Lillian Roth, speak quite openly about her own alcoholism and the way it had been arrested through this new body called Alcoholics Anonymous. Though he had heard of it, he did not know what it was all about. Lillian Roth made it stand out in his mind. He began to think that the world had never seen anything like this before for the treatment of alcoholism, and that, if possible, this was going to be his next move: to try and arrest the extraordinary wastage of human beings which came about through addiction to alcohol. He admitted that he didn't know anything about addiction then. It just seemed to be a stupid way of living.

Salter gathered some alcoholics together and they began to talk about it. They did not have any literature on Alcoholics Anonymous (AA.) at that time, but as they talked, they became keen on the idea. One of them suggested that they have an AA. meeting. So they called themselves an AA. group, as anybody could, and began to have weekly meetings.

One day, Salter could see that one member of the group, who had been a complete no-hoper when he came in to the group, "a stupid zombie of a fellow", had become different; he began to get a grip of life and to see some sort of future for himself. This chap never had another drink till the day he died and became a useful citizen. This was the start of the Alcoholism Clinic at Northfield Mental Hospital.

Though hearing Lillian Roth had stimulated his interest, Salter admitted that already he had begun to see the great value of group therapy, that people with a similar problem could help each other very much. But, AA. was a bit different, in that it did not tackle the problem of alcohol at all. In the twelve steps, which have become the essence of the A A. approach to alcoholism, alcohol gets a mention only in the first step. After that, the other steps suggest a programme of putting your life in order, a dependence on "God", an outside power, to do for the addict what he (or she) could not do for himself, providing that he became

honest about the sort of person he was, tried to make amends for the past, and became willing to pass the message on. This was something new.

From that time on, there was a steady stream of sober alcoholics coming out of what eventually became an Alcoholism Clinic. This was given quite a boost when Dr. Stirling Robertson became a medical officer to the Clinic, after he had himself been treated for his alcoholism in the same unit. Salter admitted it took some time to achieve this appointment as Hugh Birch was not at all keen on employing alcoholics. Later on, of course, he employed quite a few sober, alcoholic nurses. These were patients who then became nurses.

Salter demonstrated his compassionate understanding when he pointed out that these were people who, in his opinion, could really help in caring for the others. Most people did not like looking after alcoholics at that time; there were many comments about looking after "these no-hoppers". If they lacked an interest because of this attitude to alcoholism, they were inclined not to be involved with the alcoholics at all, and were very often derogatory in their remarks about them. Nurses who had had the problem themselves were different.

Dr. Birch, to his credit, never actually ever said "No" to this experiment. It was rather different, however, when Salter wanted to employ an alcoholic doctor on the medical staff. Dr. Stirling Robertson, who had had a problem with alcohol, came into Northfield Mental Hospital as a voluntary patient and did well on the programme. Salter argued that if an alcoholic, who had learned sobriety, could become a first class nurse and care for other alcoholics, an alcoholic doctor who no longer drank alcohol would be even more valuable. He put the proposition to Dr. Birch. Salter said: "He did make Stirling Robertson wait for six weeks, while he got confirmation about putting him on the staff. It was a very tense period. I didn't know how long we would have to wait to hear about the appointment. I persuaded Stirling to come up each day and work in the Clinic voluntarily, which he did, until he was appointed. He said himself that it was a very dicey time for him. It was just as well it came off, for I would never have been able to repeat that experiment".

An early A.A. group used to meet in St. Cyprian's Church, North Adelaide. The Reverend Norman Crawford was an Anglican priest who went some way towards being a lay psychoanalyst. He was sympathetic to that kind of activity taking place in his church. The first "Recovery Group" met in his church, too.

Salter got interested in "Recovery" in about 1963. He had been over to Sydney and heard about this group which had been started by a Roman Catholic priest and had grown out of A.A. Being so impressed with the results of Alcoholics Anonymous for alcoholics, Salter felt it would be a great help if there were something along the same lines for ordinary mentally sick people. He returned from Sydney with literature, and talked the concept over with a few people who he thought would be interested. They gathered sufficient patients and ex-patients together to make a group of nine or so. He used to take them down each week to St. Cyprian's in his old car.

The first Recovery Group was thus started by these patients from what had now become Hillcrest Hospital. It grew to about twenty, which was much too big, but there was a great unwillingness to split from this original group. There was such a great sense of personal identity with it. But eventually it did split; and, then, it continued to enlarge itself through binary fission until there were around about 50 groups. It was one of those good things that become self-propagating once it got a start. It subsequently changed its name to "Grow", when groups developed which were more preventative in direction than therapeutic and rehabilitative in scope. Salter felt fortunate to have been able to get it started.

Around about 1966, Salter became a target for the Scientologists. The Honourable Ren DeGaris, the Minister of Health, had asked him for some information about Scientology. He had produced a paper on it about that time, so he expanded it a bit and gave the Minister what he knew about the workings of Scientology and their very extraordinary ideas. This information was printed in "The News" the next afternoon, with Salter's face on one side of the full sheet and L. Ron Hubbard's on the other, looking at each other across the page. From that time on, Salter was a marked man so far as the Scientologists were concerned. They tried to discredit him and attacked what he was doing at the hospital. It was continuing in 1979.

Scientologists attacked two types of psychiatric treatment, in particular, electro-convulsive therapy (E.C.T.) and prefrontal leucotomy. Salter pointed out that one man, for whom Recovery Groups served a very important purpose in bringing his life under control, had had a leucotomy. In his opinion, the operation had contributed towards this man's mental future in no small way. Until he had a leucotomy, he was an absolutely hopeless depressive. By 1979, the relevance of the operation had diminished tremendously because of the advent of the tranquillizing and antidepressant drugs. But he thought that there was still a place for it in untreatable depression, for example, and for obsessional neuroses.

Early in his life, Salter joined the Oxford Group, also, or was it later?, called Moral Rearmament. Though his beliefs did not apparently influence his choice of psychiatry as a career, he would not agree that they were divorced from it. He could not accept that there were two separate streams because, as he put it, the essence of Moral Rearmament is that God is interested in people and what they do. He said:

"If we take time to listen to what He has to say, He'll give us guidance about important things in our life. I suppose, in a way, I always think that, if I'm open to His suggestions, whatever happens in my life is to do with His work. I often felt that what I have seen happen at Hillcrest Hospital has been a manifestation of the work of the Holy Spirit. Much of it I haven't been responsible for, even though I got the credit, for other people have come along and magically given the right contribution at the right time".

As examples, he listed Lillian Roth whose words were spoken and influenced him so much; Ron Hardwick who came on to the staff, and Dr. Ron Trudinger who was interested in alcoholics. The latter was a keen Christian and could accept them in a non-judgmental way. Dr. Beryl Bowering was a good influence, too. Later on, Dr. Leslie McLeay joined the staff as though specially provided. She had a warmth and ability for caring for people, which were great qualities to have in the medical staff of the psychiatric hospital.

Salter believed that his own perception, his ability to see a need and to fill it, was not enough. God's influence was in all things. As he put it:

"I find, in general terms, that, if I am available and keep my ears cocked towards what He is saying, He seems to provide me with something to do. I think, too, that my faith has stopped me from taking too much responsibility on myself. There are so many things that you can't know about in a mental hospital. So many unexpected things can happen that I think, often enough, that I felt I had to leave the responsibility with God and let Him look after things when I couldn't. Quite often it seemed to happen remarkably that I was alerted to things, or things were looked after in a way that I couldn't have thought out. Sometimes, I needed to be reminded of my obligations to people. Medical staff need to be reminded of their obligation to treat patients as people. It is easy to forget it and to take people for granted".

Reviewing his 30 years at the mental hospital, Salter thought that the outstanding thing that had happened was this recognition of patients as people. Therapeutic community ideas and the improvement in treatment, such as the tranquillizers and antidepressants, meant that patients were able to come to the hospital with the expectation of early treatment and rapid discharge. This led to a loss of the fear of the old mental hospital that used to keep people away until the last gasp when, very often, the illness was firmly set. The alteration in the environment, with the provision of nicely designed wards, gave totally different expectations to the patients of what was going to happen to them. They usually settled down quickly; cooperated with treatment, instead of feeling hostility. This meant that the staff were seen less as warders and were able to take up their proper role of therapists and to produce as rapid and complete a recovery as possible. When patients were seen to get better, both the staff and the other patients were encouraged.

Salter also thought that the professionalism of the staff had increased tremendously as a result of the expanded teaching of both nursing and medical staff. Nurses were now capable of being therapists and would probably take over more and more what the doctor had done in the past, and, in his opinion, perhaps do it better. He thought that one of the big factors in keeping up the standards in both Glenside and Hillcrest Hospitals was the educational programme for psychiatrists in training. This programme

maintained the interest by keeping ideas about treatment modern and using all the therapeutic possibilities to produce as effective a result as possible. A continuing stimulus was needed to keep people expectant and enthusiastic.

His greatest satisfaction, he felt, came from working as part of a team. His job as a Superintendent, the best part of his job, was to make people happy with the work they were doing, to give them a sense of the value of their work and to appreciate the amount of themselves that they gave to patients. They needed this a great deal, he believed, and, if he could do that and nothing else, and there were lots of things he could not do, that was worthwhile.

As already mentioned, Colin Haynes had a vast admiration for Bill Salter: "He was so honest and straight forward". But he admitted that Bill had a lot of critics. I became aware of this during the Second War when there was some reluctance to agree to his enlistment. It was something to do with his affiliation with the Oxford Group, the belief he was a pacifist, and the more general idea that he was a little odd. Salter himself used freely to admit he was a bit schizoid. Even though, after enlistment, he had proved his abilities and loyalty, the belief persisted. Perhaps it was his humility and charity. He was very reluctant to accept praise and was self-effacing in regard to his achievements. His view of the frustrating influence of Dr. Birch was less critical than that expressed by others. Haynes, for example, said he understood that Dr. Birch did not hand out too much initiative to the people who worked for him. Cramond expressed the opinion that Bill Salter found Birch a rather terrifying figure: "I think Bill found him very difficult to cope with at times, so that Bill's humanity, his interest in the under-privileged, his interest in the alcoholic, his wish to develop an open, humane type of hospital were frustrated by Dr. Birch".

I knew Bill Salter as a University student. He was keen on sport and very fit and strong. I can remember him on the hockey field. If Bill hit a hockey ball, everyone watched out; for he hit it so hard it seemed to travel the whole length of the field, parallel to the ground at a dangerous height. He is remembered, too, as taking an active part in the sporting events at the "Carnivals" that used to be held at Parkside Mental Hospital.

Haynes thought that Salter was a good superintendent; but he admitted that not everyone would agree with him. A lot of people queried his methods. Particularly, as time went on, some thought he was old-fashioned, that he spent too much time with patients and not enough time running the hospital. Perhaps this was associated with a rather vague manner and his apparent lack of method.

Haynes tells the wonderful story of Bill Salter's office:

"Bill had an office in the main building at Northfield Mental Hospital just across the passage from mine. It was a big office and it was always in a mess. His desk was always fully covered with piles of dockets. It probably had not been painted for 30 years. Off the office was a big toilet, a long, narrow room with the door at one end and the pedestal at the other. There were shelves all around the toilet (I well remember them) and, at about eye level, there were big glass bottles of formalin with brains in them. There must have been fifteen or twenty of these bottles around the walls. I think Bill used to sit on the toilet and contemplate these brains.

"I decided that the next time he went on leave we'd make sure that he actually went somewhere and, when he'd gone, we'd do up his office. Bill, you know, would go on leave, but stay at home, and he'd be in at work every day. Anyway, this time he did go away; I think he may even have gone overseas. At any rate, we called in the Public Buildings Department to do out his office and put in new furniture. The first thing that happened was that the Union representative came down to me and said that the men had gone on strike, that they were refusing to go near the place until I got rid of all those bottles of brains in the toilet. Well, they disappeared and never came back. When Bill returned from leave, he was quite concerned about his office because we had upset his whole system, which we had thought was chaos. He very rapidly put everything back into perspective and his new desk was again covered with stuff".

(vi)

John Cawte came into psychiatry with, as he put it, great indecision. He often conjectured his reasons for doing so. One reason that came up foremost in his mind was how moved he was during English literature classes by the books that dealt with psychiatric subjects, in particular the tragedies of Shakespeare. He had some good English teachers who really identified with Othello, Hamlet, King Lear and Falstaff. He suddenly realized that, if they were alive today, they would undoubtedly have been seeing a psychiatrist; and, hopefully, they would not have followed through with all the destruction to which indecisive Hamlet was heir.

Cawte graduated in 1949. During his residency at the Adelaide Hospital, while he was trying to decide which of the medical specialties to enter, he was reading novels that dealt with topics of similar interest, and it seemed to him that psychiatry of all the fields of medicine offered the best possibility of fulfilment of these natural interests about humanity.

There was a lot of opposition when it was found out that he wanted to be a psychiatrist. He can remember Russell Barbour, the orthopaedic surgeon, with whom he worked, taking him aside after surgery and saying: "You can't mean this! You'd be a good surgeon and be of some use to society". He recalled, too, working on Bice Ward with Dr. Ray Hone, a senior physician. His first patient was a stuporous man. He helped do the lumbar puncture, and followed up the cranial X-rays and all the other investigations that were made. On the ward round, Hone asked him to report on this patient who was quite unresponsive. He had to be tube fed, or cup fed, but could not be aroused. Cawte apologised to his senior and said: "Well, sir, I don't know much about psychiatric cases". Whereupon Hone clapped his arm around his shoulder and exclaimed: "You don't have to, my boy. You're better away from it all. We'll send this patient to Enfield (Receiving House)". He heard later that this patient had made a rapid response "to this terrible convulsive therapy" that he had been given in the psychiatric hospital.

Cawte commented: "Naturally, if you wanted some way to arouse my curiosity, you couldn't have done it any better". This extraordinary attitude and phobia of many of the teachers at the Royal Adelaide Hospital, whom he met and who had an influence on him, and who seemed to share this aversion towards this alien half of medicine, plus his friends' curiosity and dismay, contributed to the resolution of his indecision and he went to Parkside Mental Hospital in 1951. There he was trapped by the lunatic asylum at its very worst. In 1951, it was being more and more crowded with beds. It was poverty ridden, with no money whatsoever. He fell in immediately with the problems of looking after that asylum.

As an undergraduate, he had lectures in psychiatry from Harry Southwood, who had not attempted to teach the psychiatric syndromes, excusing himself on the basis that the faculty had not allowed him sufficient time. He did, however, introduce the students to the structure of the mind, as set out by Freud, and dealt with what Cawte later recognised was largely ego psychology, mental mechanisms and the transference. Dr. Southwood let his mind run in a fairly anecdotal way over his psychoanalytic experiences and interests. There was no explicit exposure to cases. This neglect had been imposed on the lecturer. It was probably a sounder reason, Cawte argued, for coming into this field than his natural interests in psychiatry and literature.

In the six to eight months he spent at Parkside, he saw enough drama but few cases that would respond readily to treatment. Fortunately, in his opinion, the experience he had at Parkside was to provide him with some notion of what Enfield Receiving House was for. It was to receive people and stop them, if possible, from going on to Parkside and Northfield Mental Hospitals. That was why the receiving house had a relatively high staff:patient ratio.

To his surprise, at the end of the year, Dr. Birch asked him to go to Enfield as Deputy Superintendent. He protested that he had had hardly any experience at all, and that surely this was a job calling for somebody more mature and better trained. But Dr. Birch wanted him to go; so, he went.

About 300 patients were being admitted to Enfield Receiving House each year when Cawte started but the next year the number grew to 400. As he stayed on, the numbers continued to grow: in fact, he recalled

that in December he would look at the admissions for the year and urge them to scale the next hundred. The numbers rose by a hundred exactly in December all the years he was there. When he left eleven years later, the admissions for the year stood at twelve hundred or thereabouts.

Cawte was at Enfield when the practice of psychiatry utterly changed. Largactil hit the market in about 1954. Suddenly, all the raving lunatics were quelled. They did not need locked doors to prevent running out, or restraining jackets, camisoles or other equivalents. He had been using reserpine to try and calm the maniacs before this, but this was a dangerous drug. So, he remembered that, when largactil came out, he kept the patients in bed under close observation, blood pressure taken every two hours and so forth. He found that this was not necessary. Largactil was a safe substance to use. It acted on the arousal centre to such a degree that the mental hospitals lost all their previous character. He was glad that he had been exposed to the conditions that existed before the use of largactil, because it meant that he learnt something about the natural history of mental illness, something that trainee psychiatrists know little of any more. Patients are exposed to major tranquillizers so quickly that no one ever sees an acute mania develop to its full glory. Electroconvulsive therapy had radically changed the treatment of the profound melancholic; but the patients who created the most distress were the noisy, raving, assaultive, combative people, where four staff members were often necessary just to feed them. They were not seen any more. The nursing staff were able to unlock the doors, get rid of the padded rooms and throw away all the restraining devices.

Cawte occupied some of his time at Enfield working for his M.D. on the topic of phenylketonuria, using patients at Northfield Mental Hospital as his subjects. As a result of the findings in this study, he suggested the introduction of a test for new born babies, the placing of a filter paper impregnated with ferric chloride in their nappies, to detect the presence of phenylketonuria, so that if there were a dietary treatment available it could be started at birth rather than later on.

After he had published an article on his work, he received a call from Dr. Ray Southwood, the Director of Public Health. Southwood informed him that South Australia had been asked to propose someone for the Harkness Fellowship which was coming up, and suggested that he apply. The Harkness representative came to see him and, before long, he had been awarded this very rewarding scholarship which he had no

idea that he could ever achieve. The award sent him to the United States of America for a year. He was a Fellow of the Commonwealth Fund of New York (Harkness Fellowships) during 1956-1957.

Cawte elected to go to the Johns Hopkins Hospital in Baltimore because he had been impressed with the work of Adolf Meyer. He also hoped to be the first Australian trainee not to go to the Maudsley Hospital in London. Unfortunately, Meyer had left the Johns Hopkins before he arrived there, and he found the place utterly changed. Management had been taken over by psychoanalytically orientated psychiatrists treating psychotics. Though he had had some training in psychoanalysis with Harry Southwood for some two and a half years in 1953-1956, he only stayed six months in Baltimore. Happily, he then went up to Harvard where the Boston Psychopathic Hospital was undertaking a practice very like that at Enfield, taking people off the streets with acute disturbances, ethnic problems and so forth. There he made many close friends and saw a lot of treatments of a group therapy type that he had not witnessed in Adelaide.

On his return home, he found that his chief task was to assist the staff to adapt to the dramatic changes that had occurred. He had to get the nursing staff, who had been trained in combative psychiatry to deal with violent and dangerous patients, to approach patients in an utterly different way from the traditional way they had been brought up to practise in the receiving house or mental hospital, now that this type of patient had disappeared. He thought he was good at that. He might not have been good at many other things, but he was good at holding staff meetings to discuss the changes and the way that the new standards and requirements in psychiatric hospitals were making demands on staff. Cawte said:

"I virtually got them to say what could be done, by sending male attendants to the women's ward and women to the male ward. They opposed this initially; but then talked themselves into it very happily, so that we dramatically changed the texture of the mental hospital where previously the segregation of the sexes had produced a very unnatural situation. They talked their way out of that and enthusiastically adopted what they thought they were planning. There was good morale at Enfield in those years, partly through the staff meetings we held. Some of the doctors resented it a bit, because they felt that their proper role was talking with patients, and here was I insisting on a lot of staff meetings, and later on therapeutic community meetings and group therapy and so forth. One doctor put it to me that I was a bit misleading, by making it appear that I was offering this

thinking-through process to the staff, when I could have issued a simple instruction and saved a lot of time with staff meetings and doctors having to break away from their patients. And, of course, he had a point. There are two ways of introducing necessary change, but I did mine largely through the way I mentioned. And I think I built up a repute at the Receiving House which I never had before or since, from the nurses and attendants who were very happy with the way things were working out, largely through their planning. So that's one way of overthrowing the traditional attitudes of nursing staff, and perhaps medical staff, through consultation on the new freedom of patients to act differently in a psychiatric hospital. I had a lot of excellent nurses and attendants who fell in with this very closely and gave me maximum support at a time when I was under a bit of stress from personal illness."

John Cawte tells an amusing, but revealing, story of his relationships with staff at Enfield which, on this occasion, involved the union representative.

"The latest achievement of the union representative, at this time I'm thinking of, was to have had an extra night person put on, because there were a number of disturbed patients at night. He wanted two staff in the main ward and one out in the extension ward. Well, one night in mid-winter I got a call that a patient of a very disturbed kind was coming in. So I got up and thought I'd go over to the hospital and be waiting. All the lights were off, of course. I opened the door to the male ward with my key to wait for him. Not a sound. I peered into the attendants' room, where all three of the attendants, including the one who'd been recently appointed as a result of all this overwork and ready to cope with violence etc., were all fast asleep in front of a roaring fire, each with a rug over him. So I stood at the door debating what to do about this. One happened to be the union representative himself. So eventually I cleared my throat sufficiently for them to wake up. I said: 'I'm up here not to see what you're up to, but because there's a patient coming that I have to wait for. He needs to be met'. At the end, when the patient had come in and everything had settled down, the union representative took me aside and said that he was just resting after a heavy night locked up. But I'm sure he was in fear and trembling that the incident would be reported to exactly the person he didn't want to hear about it. So I didn't report it. I did tick him off a bit myself and say: 'You'd better start playing crib or something if you want to stay awake

when there's nothing happening, because you can't be asleep'. But I didn't report it to Dr. Birch, and I think this, in the long run, gave me some advantage with him, because - I don't think he thought I was blackmailing him about the incident or anything like that - but he was very grateful that it wasn't reported because it would have undermined his status considerably as the union representative"

Cawte recounted another story that illustrated the strength, the violence and the destructive power of the manic patient and the dangers that staff were exposed to in their protection and control.

"Dr. Birch used to come to see me on Friday afternoons. On one occasion, I had a very manic woman, a very powerful lady, in the first female room just next to my office, near which Hugh had parked his new blue Jaguar car. Suddenly, as we were having our usual afternoon tea of scones, strawberry jam and cream, Hugh Birch exclaimed: 'What's that disruption?'. And we saw the figure of this big naked woman, with her hair streaming down her, dust everywhere, come through the roof. I had never seen a patient able to do this before. She must have up-ended her bed and jammed it against the wall, climbed up it, pushed through the ceiling and gone through the roof. And there she was, picking off a lot of tiles and flinging them round with back-hand flips like Frisbees, on a beach. She got them spinning through the air. Suddenly, she saw the Jaguar car. There she was taking careful aim, and Hugh was saying: 'Good God, doctor! Get all the attendants'. Fortunately, she didn't inflict a blow on this marvellous car, for which I am grateful. But an attendant, trying to get ladders to go through the room, up through the ceiling and under the roof, broke his arm. There was all hell to pay. This was in 1953, before largactil. Such a thing could never have happened with a sniff of largactil."

The year he spent in America provided Cawte with a number of benefits. In the shorter term, he tried to implement many of the things he had seen happening with more confidence than he would have otherwise. One was the therapeutic community where patients could discuss the day to day running of their management while in hospital. Though at times overdone, it did return to the patients a degree of self-respect and awareness that did not exist before. Sometimes genuine complaints about the attitudes of doctors, nurses and attendants came up and this proved valuable. He took that experience with him when

he moved to Prince Henry Hospital in New South Wales after he left Enfield in 1963, and established a therapeutic community. It ran there for a while. Mostly, the medical staff were not very keen on spending their valuable time to hear patients sound off in this way. They would rather concentrate on the individual relationship.

In the longer term the close friendships he made were invaluable. A lot of his subsequent career has been spent on invitations to various parts of America. "And now when I go back to these places it's a great pleasure to mix with old acquaintances where I'm still made to feel a favourite son."

Cawte was running Enfield as a therapeutic community when Bill Cramond arrived from Scotland. The latter found his views to be very advanced. "He was doing at Enfield, and was much nearer to achieving, the sort of things that I had come out to do." He described Cawte as "very much his own man with a kind of entrepreneurial skill. He stood up to Birch. John was able to do a lot that Birch didn't approve of, didn't understand. There was a kind of running battle between the two of them all the time. John was able to get away with a lot".

Regarding their relationship, Cramond told me:

"John was a great joy to find. He and I had a kind of ambivalent relationship, because I had come out to do all the things that John knew had to be done and indeed that he had done at Enfield; and I was now doing in the wider setting. So, John approved of what I was doing, but I was a rival to John because I was doing it and not him. It was a bit awkward. John took me through my paces and could be quite sharp with me."

John Cawte was credited with having influenced medical students and young doctors to enter psychiatry. He admitted that he wrote an article in 1952, at their request, which was published in the Adelaide Medical Students' Society Review. It was a painstaking article on the management of acute mania. He described the case of a patient, an educated man, who was particularly difficult to manage, and who required physical restraint with a straight jacket. Cawte recalled how he said to the patient: 'If I take this jacket off, as I want to do, can I rely on you not to hit me?' He was an angry man, and he said: 'No,

you'd better leave it on me while I feel like this.' He had recognised that the restraint was useful to him while he was so assaultive and unpredictable.

He wrote this case up in some detail. It was quite a complicated article and went into all the possibilities in managing cases like this with sedatives like paraldehyde and so forth which just did not reach them. At the time, it made an impact on the readers of the Medical Students' Review. It impressed that mania had not reached the point of control in hospitals, but was a very interesting illness because the doctor had to come very close to a severely disturbed person to try and obtain a history and get at the psychodynamics and so on. That could be exciting.

The article, plus a number of talks he gave to various organisations on what was really happening at Enfield, may have influenced some of the people; but he thought that the word had got out that a revolution in psychiatric management was occurring as a result of the introduction of largactil. He did recall, however, that he was invited by Dr. Basil Hetzel to present a patient at the newly opened The Queen Elizabeth Hospital. The meeting was reasonably successful. He had interviewed the patient briefly and discussed the case. Then Basil Hetzel had taken it upon himself to criticise psychiatry as it was being conducted and say how deplorable it all was. Cawte thought these comments were somehow directed at him and reacted sharply. He said something like: "If you think it's so deplorable, why don't some of you come and do it instead of sitting here in this comfortable hospital?".

Whatever the reasons, Cawte admitted that a whole stream of young graduates entered psychiatry. Brian Shea was the first.

Cawte grew up in Streaky Bay on the west coast of South Australia. His house was nearby an Aboriginal camp in the gully. From his own experience, he had some idea of what went on in Aboriginal camps, although it was not anything like as desperate as camps in the larger centres, or later when alcohol became a more prominent trigger to disturbances. He took this experience with him to Enfield and, while there, he wrote an article on Aboriginal patients in South Australian mental hospitals and the problems of

trying to treat them in Adelaide. Many were flown down from the Northern Territory with no English at all, speaking only their tribal language.

At about that time, Professor Andrew Abbie, the Professor of Anatomy at the University of Adelaide, invited Cawte to join an expedition that he had organised to Kalumburu in the north Kimberley area. Abbie had remembered Cawte because he had done well in anatomy and because he was interested in psychiatry. At Kalumburu Mission, he discovered several psychotics among the aborigines. By that time, antidepressant drugs were also available and one of the Aborigines responded so well to it that he was able to reveal a lot. The man had been educated enough to speak a little English and Cawte learnt about the Aboriginal religion at Kalumburu and about their medicine. He wrote this up in fascinated detail though he did not publish it at the time. It later became the first chapter in his book, "Medicine is the Law".¹⁷

It was this trip with Abbie that made him think that he would have to have a job that would make this kind of involvement with Aborigines more accessible. He had been awarded an M.D. of the University of Adelaide in 1960 and obtained the Diploma of Psychological Medicine from the University of Melbourne in 1961. He chose an academic job and the first one offering happened to be in the School of Psychiatry at the University of New South Wales. His fame as a transcultural psychiatrist stemmed from that decision, because the Head of the School, the English Psychiatrist L.G. Kiloh, approved of field work.

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My psychiatric life spanned these years and I had personal experience with all of these personages whose entry into psychiatry and whose contributions have been described in the last pages. It is now necessary to revert to my own story to add coherence to the events that are to follow.

I went into private practice in March 1946. I had no senior qualification. But, at that time, a senior qualification was not required for entry into private practice. Quite a few consultant surgeons and

physicians did not have a senior qualification. All that was necessary was for your medical colleagues to accept that you had the necessary experience to be regarded as a specialist.

I recall that, soon after I went into private practice, I met the late Dr. Jimmy Burnell, one of the first specialist genito-urinary surgeons in Adelaide, outside Wakefield Street Memorial Hospital. I have already referred to the association that Hugh Birch had with him. He said he understood that I had recently gone into specialist private practice and wanted to give me a piece of advice. This was: "If you give a service you will never want for patients." I willingly accepted this advice, acted on it and never looked back. It also became part of my philosophy of life.

In 1946, three other significant events occurred. First, I obtained a half-time research grant from the National Health and Medical Research Council to pursue an investigation into the startle reactions of ex-servicemen suffering from "war neurosis" This was carried out, with quite primitive equipment (there was little money post-war for such luxuries) in the Department of Physiology, University of Adelaide. The Professor of Physiology, Sir Stanton Hicks, was my supervisor, but also my mentor and friend, and I record my gratitude for his support. Though I never published anything then, I did demonstrate the significance of hyperventilation in the production of some of the symptoms complained of, and show that one could decondition a person to the startle reaction to loud noises. It has been suggested that I was probably the first person in Adelaide to use behaviour therapy. The interest generated in hyperventilation, during this period, led to the publication, in 1949, of my paper on "The Hyperventilation Syndrome".¹⁸

Second, I was made a Foundation Member of the Australasian Association of Psychiatrists. Dr. Birch had discussed the formation of the proposed association with me while I was still at Parkside Mental Hospital. I felt very honoured that, as a quite junior psychiatrist, I had been considered worthy to be made a Foundation Member.

Third, in March, 1946, I was appointed an Honorary Assistant to the Director of the Psychiatric Clinic at the Royal Adelaide Hospital. This was the first acknowledgement by the medical staff that psychiatry had a place in a general teaching hospital. Dr Birch was the Director. There were three or four other

people in the Clinic, with the title of Assistant to the Director. This nomenclature excluded us from being members of the Honorary Staff and illustrated the low value placed on psychiatry at that time.

At the Psychiatric Clinic at the Royal Adelaide Hospital, I received consultations from other departments and used drug therapy and limited psychotherapy. We had no access to beds and so could not undertake any inpatient treatment. A few patients, however, did accept treatment in a private hospital on my recommendation.

My first period in private specialist psychiatric practice extended from 1946 to 1949. My referrals were from other doctors and occasionally from lawyers. The categories of disorder included neuroses, depressive states, occasional manic states, schizophrenia, personality disorder and alcoholism. Full-coma insulin therapy was carried out at St. Anthony's Private Hospital, Joslin¹⁹; sub-coma insulin and electro-convulsive therapy at both St. Anthony's and St. Margaret's Private Hospital, Payneham.²⁰

Penicillin had also been discovered. I recall treating a patient, whom I had diagnosed as suffering from general paralysis of the insane (G.P.I.), with the new drug with very good results. It was interesting how the correct diagnosis came to light. I had thought this middle aged woman was suffering from an atypical depression and decided to use electro-convulsive therapy (E.C.T.). However, one E.C.T. caused such a prolonged period of disorientation and confusion that I decided that there must be an underlying organic cause. A positive Wassermann Reaction (W.R.) confirmed the correct diagnosis. I subsequently used this exceptional reaction to E.C.T. to alert me to possible underlying neuropathology.

I undertook psychotherapy, both short and longer analytically orientated, and did some narcoanalysis and hypnosis, but I was never very attached to the latter two methods of treatment. Pre-frontal leucotomy was not excluded from the means of helping patients. Quite a literature had developed on this method of treatment, and books had been published. It was mostly being used for patients with chronic, severe depressions and disabling obsessive compulsive disorders. Having assisted at the first operation performed in the State while I was at Parkside Mental Hospital and seeing the dramatic result of transverse prefrontal leucotomy, I felt that patients who had failed to respond to other methods of treatment should be given the

opportunity to obtain benefit from psychosurgery. It must be remembered that this was before the days of the psychotropic drugs. We had no phenothiazines and no antidepressants.

The results of pre-frontal leucotomy, mostly performed by Mr. T.A.R. Dinning, neurosurgeon, were quite good. The decision to operate was never entered into lightly. I came to the conclusion that a strongly obsessive underlying personality was a prerequisite for a satisfactory result. There was not then the violent antagonism to psychosurgery as there is now. The present community attitude is unfortunate, because I think there are a number of patients, who suffer intensely as a result of their psychiatric disorder, who would benefit greatly from the modified forms of psychosurgery now available.

In 1948, prior to leaving for London, I had received the Diploma of Psychological Medicine from the University of Melbourne. In the Part I examination, I failed neuroanatomy; and in Part II, I failed neuropathology. I can recall how I resented having to study these two subjects in such detail; for, having been in psychiatry for some six years in the Army, at Parkside Mental Hospital and in private practice, I could see little value in a detailed knowledge of either of these subjects in the diagnosis and treatment of patients. I was fortunate that, as an ex-serviceman, I had to repeat only the subjects failed and not the whole Part I and Part II, as was the usual requirement.

By 1949, I had come to the conclusion that I was inadequately trained for the job I was undertaking. Part of the reason for my coming to this decision was the degree of anxiety that was being generated in me by difficult patients. Part, I think, was just that I was becoming restless and felt the need for change and the opportunity to expand my therapeutic horizons. So, in the middle of 1949, I left for the Maudsley Hospital in London to extend my postgraduate studies.

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I arrived at the Maudsley Hospital, Denmark Hill, London, in the middle of 1949, and was placed initially with the Professorial Unit under Professor (later, Sir) Aubrey Lewis, the well-known Head of the Maudsley Hospital and Professor of Psychiatry at the University of London. Aubrey Lewis was a graduate of the University of Adelaide. I had been fortunate to have been given letters of introduction from some people in Adelaide, such as Ray Binns²¹, who had been in the Medical Course with him. These personal recommendations undoubtedly assisted me in obtaining a post at the Hospital in the first place; and, I suspect, ensured that I was given the opportunity to receive a wide range of training. In his unit I learned to complete the very extensive Maudsley history which placed great emphasis on detail and the need to confirm what a patient said from outside sources, such as relatives or friends or the employer. It was Aubrey Lewis's dictum that every patient was an unreliable witness.

After some six or seven weeks in the Professorial Unit I was transferred to the unit run by Dr. Denis Leigh. Here I was thrust into doing psychotherapy by the method of Finesinger, the so-called "insight therapy", which was a hobby of his at that time. This involved frantically writing down verbatim everything that the patient said. Trains of thought, which you wanted to hear more about, were encouraged by your writing frantically, showing interest and making encouraging noises. If, however, the patient deviated from the line of thought that you wanted to explore, you immediately lost interest, even looked out of the window, and certainly did not make any encouraging noises. Having had two or three years of practice in my own form of psychotherapy, I did not find this method at all attractive, though Bill Salter, when he was at the Maudsley, had a different view. Of these briefer types of psychotherapy, I personally was more attracted to that expounded by Carl Rogers, in which you kept the flow of thoughts going by asking a question on the last thing a patient said. For example, if a patient said that his mother had died following the birth of her sixth child and then remained silent, you would, in a short time, say "You said a moment ago that your mother had died after the birth of her sixth child?".

After six months with Denis Leigh I was transferred to the Department of Child Psychiatry under Dr. Kenneth Cameron. Gordon Prince was the Senior Registrar in the Department, and he and I became firm friends. Gordon Prince was having a Jungian analysis at the time. One of the consultants in child psychiatry was a Dr. Gillespie, who was a Freudian. I found this six months in child psychiatry extraordinarily valuable, and of course made use of it when I returned to Adelaide and sought an appointment in the Child Guidance Clinic at the Adelaide Children's Hospital.

My last appointment at the Maudsley Hospital was to the outpatient department as a psychotherapist. I remained in this post until I returned to Adelaide in about March 1951. I had a number of supervisors: Emanuel Miller, an eclectic and author of a number of books; Clifford Scott, a Canadian and an analyst of the Kleinian school; Foulkes, a group psychoanalyst; and E.A. Bennet, a Jungian, who also took a personal interest in me as I had met him socially through mutual friends.

When I returned to Adelaide I did so in rather a hurry because of personal problems, and it was E.A. Bennet who took me out to dinner and encouraged me not to feel too disturbed because I was having abruptly to break off my own personal psychoanalysis. As he put it: "No analysis is ever complete; there are always problems and matters which can be further analysed".

One thing of interest during this period was the realisation that no matter how "completely" a person had been analysed, he could also show very human frailties. Foulkes, for example, developed an overriding anxiety about becoming bodily cold, after he had had a severe attack of pneumonia. Before he would start one of his tutorial groups, he would carefully check on doors and windows to exclude draughts and make sure that the heater was turned up sufficiently to warm the consulting room adequately. Clifford Scott also became distressed at the loss from the outpatient consulting room of a rubber stamp, which could be rotated to print different dates, and obsessively kept questioning me about whether I had been able to track it down, especially as he suspected that one of the previous registrars had it in his possession.

It was also fascinating at the Professorial Grand Round on a Monday morning to have a case presented by a registrar and then hear all the eminent consultants at the Maudsley frequently differ not only on the diagnosis, but especially on the methods of treatment.

I was associated with a number of people at the Maudsley who have subsequently become very famous. D.L. Davies, the Dean at the time, was a man with a rather sinister reputation. He wore rubber-soled shoes and tended to, as it were, creep up on people. The Maudsley was a very paranoid place because your appointment was only for six months and you never got much prior warning at the expiration of the six months whether you were going to be reappointed or not. Whether you were, in fact, reappointed was often blamed, I think quite erroneously, on David Davies. I had a wonderful run at the Maudsley, being there for nearly two years, and I believe that David Davies took a personal interest in me. So I have fond remembrances of this man.

James Anthony, who subsequently became a Professor of Child Psychiatry in the United States and did some eminent research work on children, was a contemporary, a Senior Registrar at that time. He was under a Freudian analysis, and one of the stories told about James was that if, following a session, he saw his patient board a bus, he would purposely miss that bus so that he would not be on the same bus with him or her. This was quite different from the Jungians who did not mind, as it were, associating in a social sense with their patients.

Anthony Storr and David Stafford-Clark were registrars at that time, and both have written books. Gerard Vaughan was a Registrar in Child Psychiatry. He became a Member of Parliament and was for a time Minister of State for Health. Others there were Murray Jackson, an Australian and a Consultant Psychiatrist at the Maudsley, Wilfred Warren, Felix Post, Desmond Pond, and, in Psychology, the redoubtable Professor H.J.Eysenck. Most of these gentlemen subsequently received knighthoods.

I enjoyed my stay at the Maudsley. I gained much valuable experience. Even more worth while was the realisation that the great men at the Maudsley also had limitations imposed on them by the obscurities of mental disorder, that diagnosis could be difficult and treatment uncertain; that causation was complex and

solutions rarely simple. They struggled to elucidate psychiatric problems and experimented hopefully with new treatments. It was reassuring for a psychiatrist living on the other side of the world.

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On my return from England in 1951 I re-established my private practice. There was some difficulty in acquiring consulting rooms as these were at that time in short supply. Mr. Alan Hobbs, the surgeon with whom I had been associated before I left for England in 1949, kindly agreed to let me share his rooms on a limited basis. The house I bought was big enough for me to use two front rooms for consulting. I consulted in this way at Goldsborough House in North Terrace and at home until Dr. Hobbs and I moved to Elizabeth House, North Terrace, towards the end of 1956.

I also applied for appointment to the honorary staff of the Adelaide Children's Hospital. The six months' experience in the Children's Department of the Maudsley Hospital gave me as much, if not more, experience than the Clinical Assistant who was then on the staff and I was appointed an Honorary Clinical Assistant in July 1951. I subsequently became Honorary Assistant Psychiatrist, when Dr. R.T. Binns was elevated to the position of full Honorary Psychiatrist, and took over as Honorary Psychiatrist when Dr. Binns retired.

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Raymond T. Binns entered psychiatry in a straightforward fashion. Shortly after completing the degree of M.B.,B.S. from the University of Adelaide in 1923, he went to England and worked at the West End Hospital for Nervous Diseases. On his return to South Australia, he entered general practice but continued his studies in neurology and psychiatry which he had commenced in London. He obtained his M.D. in 1937

and his Membership of the Royal Australasian College of Physicians in 1940. He was elected a Fellow of the College in 1956.

Ray Binns enlisted in the A.I.F. in July 1940 and was sent to the Middle East. A major in the 2/8 Field Ambulance, he and a number of his men were taken prisoner of war at Derna, Libya, in April 1941. This, however, was the beginning rather than the end of Major Binns' war service. He and Capt. E.W. Levings of Leeton, New South Wales, forthwith set up an Emergency Aid Post at Derna, and for about four months attended casualties of many nationalities. Many paid tribute to the work of these two doctors and owed their lives to them. Major Binns was awarded an O.B.E. for this work. From Derna, he and his men were transferred to a Prisoner of War. camp in Northern Italy, where he had the care of some 4,800 war prisoners, mainly Australian and New Zealand. In 1943, he was repatriated under an exchange of prisoners scheme and finished his war service in Australia.

Back in civilian life, Dr. Binns set up as a psychiatrist in private practice. In 1938, he had been appointed to the newly opened Psychiatric Clinic at the Adelaide Children's Hospital with the status of an Honorary Assistant Physician. He resumed this position at the Adelaide Children's Hospital on his return and also became Visiting Psychiatrist to the Repatriation Department and Command Psychiatrist to Central Command (Army). Another appointment was that of Official Visitor to Parkside Mental (later Glenside) Hospital.

After the War, as the importance of the Psychiatric Clinic at the Adelaide Children's Hospital became recognised, his status was raised to Honorary Psychiatrist, an office he held until his retirement in 1961.

When the Australasian Association of Psychiatrists was formed in 1946, Dr. Binns was one of the Foundation Members and was secretary of the South Australian Branch for many years. When the Association became a College (and later a Royal College) he was an original Fellow.

He took a leading role in opposing some of the provisions of the Alcohol and Drug Addicts (Treatment) Act 1961, and, in 1963, he was appointed by the Governor a member of the Advisory

Committee to consider amendments to this Act. As a result of the Committee's recommendations, the Alcohol and Drug Addicts (Treatment) Act 1961-1964 was proclaimed, to take effect from 1 January, 1965. Dr. Binns was a member of the first Alcohol and Drug Addicts Treatment Board and served from 1965 to 1974. As one of the original Board, he was instrumental in establishing the first alcohol treatment centre outside a mental hospital in this State.

Ray Binns was a member of the Anthropological Society of South Australia, with a particular interest in the welfare of aborigines, and was President in 1952.

A quiet, unassuming, rather shy man, Ray Binns was a wise physician, a competent psychiatrist and a champion of the disadvantaged. He can be considered to have established the sub-specialty of Child Psychiatry in South Australia.

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During my period at the Maudsley Hospital, I had had a personal psychoanalysis with Edna Oakeshot, who had been the second wife of the noted psychotherapist and author, Dr. Michael Balint. The experience I had gained in the Children's Department at the Maudsley and my personal analysis changed my orientation more towards psychotherapy. These events combined, too, to influence me to join the Honorary Staff of the Adelaide Children's Hospital.

However, in private practice, it was necessary for me to treat mostly adult patients. The National Health Scheme allowed rebates to patients on fees for technical procedures, which varied with the procedure, and on a flat rate for consultations, so much for the first consultation and a much lesser amount for second and subsequent consultations. The rebate paid was independent of the specialist concerned and the time involved. So, a consultation lasting five or ten minutes with one specialist attracted the same rebate as a consultation lasting an hour or more from another. The rebate for a technical procedure, such

as electro-convulsive therapy (ECT), was much higher than for a long consultation. Because of these external circumstances, it was much more lucrative to treat a patient in hospital with ECT than to undertake psychotherapy with a patient which could involve regular hourly consultations over a long period of time. The examination and treatment of children in private imposed a real financial burden. I used to allow one and a half hours for a first consultation, one hour to obtain the history from the mother or other informant and a half-hour for the examination of the child. Subsequent consultations would last an hour. The low rebate allowed by the Health Fund made such work expensive both for the patients and for me. Consequently, in order to live, I had to limit the work with children and the number of adult patients taken on for psychotherapy.

Before the advent of the psychotropic drugs, the treatments used for the psychoses were full coma insulin and ECT. At first ECT was given 'straight', with adequate staff controlling the violent, convulsive movements of the patient; but this was modified when muscle relaxant drugs became available. Initially I used intravenous sodium pentothal and scoline, later replaced by intravenous sodium amytal and brevidil. We did take chances in those days: when scoline and sodium pentothal were mixed in the one syringe, the mixture flocculated. With some anxiety we injected this cloudy material, but the mixture worked perfectly well and never gave us any alarm. Sodium amytal and brevidil mixed as a clear solution.

I think I was the first in South Australia to use two new drugs. I treated patients suffering from hypomania with lithium carbonate soon after my return from England, having read John Cade's original paper. The lithium was given on six days of the week to avoid toxicity which was known to occur, and the dose was reduced if the patient complained strongly of a metallic taste in the mouth. However, lithium carbonate tablets were hard to obtain in those days, and because of the possible toxicity it was replaced by chlorpromazine (Largactil) when this became available. I never did use lithium again because I left private practice before its popularity returned.

I was the first person, I think, to use a monoamine oxidase inhibitor. I had read about the treatment of tuberculosis with iproniazid (Marsilid), and how doctors in America had observed that the patients "danced in the wards". This had led to its use in depressive states. Having seen an advertisement at a medical

conference recommending Marsilid in the treatment of angina pectoris, I realised that the drug was available and decided to try it with some of my depressed patients. I was impressed with the results in some patients. Subsequently, I wrote a paper on the combined use of ECT and Marsilid²³, showing to my satisfaction that the combination reduced the number of ECTs required to lift the depression and shortened the period in hospital.

The neuroses were treated by psychotherapy, both long and short term. Because of time and expense, short term psychotherapy predominated, but I did have some success with two long term patients, one whom I treated for 470-odd hours over a period of seven years. I also used some behaviour therapy, although this was not of a very structured type, none as structured as when I desensitised returned soldiers to noise by the use of records of war sounds.

Sedative drugs used were mostly barbiturates in those days. I found 100 mg tablets of amylobarbitone (Amytal) very useful in the treatment of anxiety attacks. When the minor tranquillisers became available I added them to the major tranquillisers and the antidepressants. I found monoamine oxidase inhibitors (MAOIs) useful drugs, especially for those cases which I diagnosed as reactive, or atypical, depressions. MAOIs were sometimes described as 'psychic energisers', and I believed they acted this way and were valuable in the treatment of what I called 'the flat battery syndrome'.

The period at the Children's Hospital was a very productive one. Here, as the result of my experience in the Child Guidance Clinic team, fortified by my findings with children and adolescents seen in private practice, I was forced to reshape the views on child psychiatric theory and practice with which I had returned from England. I had come back with my feet planted firmly in the field of psychotherapy. I had utilised play therapy in an individual and group setting and given support and advice to parents.

Then I had some most unsettling experiences. A very behaviourally disturbed 10 year old boy had been attending the Clinic for some months without benefit. His aggressive behaviour occurred episodically and often as the result of little or no provocation. There were other unusual features, so much so that, when an electroencephalogram was installed at the Hospital, I requested a reading. The result was abnormal: the

tracing showed a left temporal lobe dysrhythmia. Treatment with laevoamphetamine sulphate (Benzedrine) produced a dramatic improvement which was maintained. In private, an adolescent boy presented with an impulsive, violent conduct disorder. The electroencephalogram revealed sub-clinical epilepsy. Treatment with anticonvulsant drugs dramatically stabilised his behaviour. His mother had had german measles in the first three months of her pregnancy. This revelation of the possible connection between abnormal brain states and disturbed behaviour aroused my interest in cerebral dysrhythmia and the prescription of drugs in its treatment.

I had also been impressed with various abnormalities in the pattern of the scores in the sub-tests of the WISC (Weschler Intelligence Scale for Children) and tried to relate these abnormalities to the type of cerebral dysrhythmia. This line of research was not productive. I did, however, write an article²⁴ that showed that what I called "essential conduct disorders" were significantly associated with abnormalities in the EEG.

When Dr. Binns retired I was the only psychiatrist on the honorary staff of the Children's Hospital. In order to maintain a service and provide support for the child guidance team of psychologist, social worker and speech therapist, I agreed to become half-time Director of the Department of Psychiatry, being paid for four sessions per week and giving one unpaid session in order to maintain my honorary status. This arrangement continued until a full-time director was appointed in the mid 1960's. I retired in 1970. My total service with the Adelaide Children's Hospital was 19 years.

(xii)

In 1954 I was invited to become Chairman of a Standing Committee of the South Australian Council of Social Service on Mental Health, and was Chairman of this between 1953 and 1956. During this time we held a number of meetings, and eventually a seminar in 1956 at which it was agreed that a South Australian Association for Mental Health should be formed. Dr. Alan Stoller²⁵ from Victoria was very influential in

interesting me in the Mental Health movement. He gave the keynote address at the Founding Ceremony. The story of the South Australian Association for Mental health is told in Chapter 4.

I was appointed as a member of the Executive Board of the World Federation for Mental Health in 1960 at a meeting in Edinburgh that I attended, and served on this Board between 1960 and 1964. The Australasian Association of Psychiatrists (AAP) was actually the Australian Member of the World Federation for Mental Health (WFMH), as there was at that time no national body representing the Mental Health Associations. Although the South Australian Association for Mental Health was a member organisation of the WFMH, it could not, of course, represent Australasia. The AAP was the organisational member for some considerable time, and the College (Royal Australian and New Zealand College of Psychiatrists) is, I think, still a member organisation.

The Australian National Association for Mental Health was not formed until 1968, and I was a representative on this from the South Australian Association for Mental Health, and became the Honorary Treasurer in 1970 when the office was moved to South Australia.²⁶

The Australian and New Zealand College of Psychiatrists (the Royal prefix came much later) arose, of course, out of the Australasian Association of Psychiatrists (AAP). The decision to form a College was, as it were, catalysed by the refusal of the Queensland Medical Board to recognise the AAP. DPM At that time, the Diploma of Psychological Medicine (DPM) was offered only by the Universities of Sydney and Melbourne. It was not easy for medical graduates of other Universities to train in psychiatry and obtain a higher qualification. The AAP decided, therefore, to set up its own examination. Dr. Joan Lowry, from Queensland, was the first member of the AAP to obtain the DPM. The Queensland Medical Board refused to register her AAP.DPM on the grounds that an Association was not an examining body. It was therefore decided to transform the Association into a College along the lines of the other Colleges such as the College of Physicians and the College of Surgeons. As a result, the Australian and New Zealand College of Psychiatrists (ANZCP) was founded in 1964, when Dr. Reg Medlicott of New Zealand was the President of the AAP. Dr. Eric Cunningham Dax was the first President in 1964, and I followed as President in 1965-1966.

The big changes in treatment that occurred over this period, 1951-1968, were as a result of the introduction of the psychotropic drugs. Full coma insulin was displaced by the phenothiazines. It was found that schizophrenia responded just as well to phenothiazines alone, or in combination with ECT, as with full coma insulin. It was also far less time-consuming and demanding of staff time. Sub-coma insulin was persisted with, mainly as a means of helping people to regain appetite and to put on weight, and as a means of keeping them in hospital happily, or more happily, while initial psychotherapy was undertaken. Electroconvulsive therapy was displaced, or partly displaced, by the antidepressant drugs. Melancholia could respond to the cyclic antidepressants such as imipramine and amitriptyline, and mania could be suppressed by means of phenothiazines; and later by lithium.

Leucotomy was still used, but far less often. In my own practice it was used mainly for severe cases of obsessive compulsive neurosis, especially if this was combined with depression.

As a result of the availability of the psychotropic drugs, patients tended to spend shorter times in hospital. This was a great advantage to patients but had a strange disadvantage to psychiatrists: we tended to spend less time in the hospital. When we undertook full coma insulin therapy we all had to be at St. Anthony's Hospital around about 10-10.30 a.m. and stay there till 11.30 at least so that we could tube-feed our patients with glucose solution and wait until they had recovered from the coma. As a result of this necessity, we psychiatrists tended to gather at St. Anthony's Hospital and have morning tea together. This was not only a socialising opportunity, but an opportunity for discussing treatments and difficult patients. When the periods in hospital became shorter, the periods in the rooms became longer. I think it was this longer period of isolation in the rooms with the solitary patient, with far less contact with one's colleagues, that finally decided me to leave private practice and go back into government in February 1968.

(xiii)

I was part of the link between Hugh Birch and Bill Cramond. I had become Executive Chairman of the South Australian Association for Mental Health when it was founded in 1956. On the announcement that Bill Cramond was to be appointed Superintendent of Mental Institutions on the retirement of Dr. Hugh Birch, I, as Executive Chairman of the South Australian Association for Mental Health, wrote to him.

I wrote welcoming him to Adelaide, extending the co-operation and support of the Association and offering to entertain him on his arrival. It was interesting to hear later what Bill Cramond thought of the letter and how he reacted to it. In a taped interview with Professor Ross Kalucy²⁷ in Sydney in May 1981, Cramond said:

"When I was appointed, when I was still in Glasgow, I got a letter from a chap called William Dibden, and....it was kind of welcoming me to South Australia and saying that, you know, if there was anything he could do, he would be very willing to help and he was in private practice....and being young and inexperienced and going out to this new country and quite uncertain, I didn't know how to take this. I wrote back a civil little letter as I recall, but I didn't know what this meant. Because of the National Health Scheme in Britain and my own predilections, private practice was something that didn't interest me and I didn't know how to interpret this friendly approach. And I may say they made me very welcome and, I remember, they gave me a dinner at the Army and Navy Club and there was a child psychiatrist, who's now dead, out from London."

He referred to Kenneth Cameron.²⁸

By the time Cramond arrived in Adelaide in 1961, many changes had occurred and the soil was ready for new fertilization. Hugh Birch had made some advances in spite of his physical handicap and the obstructions imposed on him by the difficult times during which he administered the mental health services. But others had contributed. Harry Southwood had trained himself to become the founder of psycho-analysis in South Australia. Bill Salter at Northfield Mental Hospital (later to be known as Hillcrest

Hospital) had already supported the establishment of self-help programmes such as Alcoholics Anonymous and Recovery Groups and to encourage the provision of Industrial Therapy for his patients. John Cawte at Enfield Receiving House had transformed the entire character of the hospital, and I had formed the South Australian Association for Mental Health.

CHAPTER 3

IN PURSUIT OF PREVENTION.

(i)

In 1955, a report was presented to the Minister for Health, Commonwealth of Australia, on the mental health facilities of all the States of Australia, and an estimation of basic needs, by Dr. Alan Stoller, Chief Clinical Officer, Mental Hygiene Department, Victoria, with the assistance of Mr. K.W. Arscott, Administrative Officer, Commonwealth Department of Health. This came to be known and was referred to as "The Stoller Report".

I had known Alan Stoller in the Army when I was psychiatrist at the 105 Adelaide Military Hospital, now the Daw Park Repatriation General Hospital. I recall him as an energetic, high-spirited, enthusiastic, friendly, sociable man who could become slightly hypomanic at times. One of his well-remembered party tricks was to take a run at a lounge in the officers' mess, up the back, along the vertical wall behind and then down the other side. When he left the Army, he became Consultant (Psychological Medicine) to the Repatriation Commission Headquarters in Melbourne, Victoria. I came under his influence, again, when I started the Psychiatric Out-patient Clinic for the Repatriation Commission in Adelaide at Keswick Hospital.

In his report, Stoller had this to say about South Australia in summary:

"South Australia has been, as a State, relatively backward in its psychiatric development. The only psychiatry of any consequence, until the post-war period, was purely mental hospital psychiatry and this was very isolationist

"The mental hospitals, though they had improved considerably recently, needed more and better professional staff. Professional staffing establishments were very low. Training had to be made available or people sent to other States for training. Mental hospitals could not afford to be short of key personnel, because training facilities were so poor in South Australia.

"The mental hospitals needed to come out of their isolation. Staff needed to get out more among the people and people needed to be brought more closely in contact with the hospitals.

"There was considerable room for development of out-patient activities and for giving a psychiatric service to other State departments, private homes and public health personnel.

"The cost of the mental hospitals was rising, but years of gross neglect needed to be overcome

I saw quite a lot of Alan Stoller at meetings of the Australasian Association of Psychiatrists and at other times, and became aware of his enthusiasm for the mental health movement. The World Federation of Mental Health grew out of the Third International Congress on Mental Health held in London in August 1948, and became a frequent subject for discussion between us. The concept of "mental health" as against "mental illness", of prevention as opposed to the treatment of disease, was attractive, even more so since my experience in the Children's Department of the Maudsley Hospital.

It was, therefore, not exceptional when, in August, 1954, I accepted an invitation from the Central Committee of the South Australian Council of Social Service to act as Convener of a Standing Committee on Mental Health. Miss Margaret Holmes, an English Psychiatric Social Worker then employed in the Child Guidance Clinic at the Adelaide Children's Hospital, was the Honorary Secretary, and Mr. L.S. Piddington was the third member. He was, at that time, the senior psychologist to the Education Department who did much for the mentally retarded and after whom the Piddington School at Strathmont

Centre was subsequently named. The Central Committee nominated a member, who, if I remember correctly, was Miss Mary Smith, a well-known psychologist.

Over the next two years, the Standing Committee made enquiry and held several meetings with other agencies to determine whether a new association, an Association for Mental Health, was desirable, needed and acceptable. There seemed to be general support. So, to test the reaction of the public at large, the Committee arranged a Congress on Mental Health, with the title "Growing Up", at the Freemasons Hall, from 23-25 November, 1955. On the programme there was a tear-off for those present to indicate their interest in the formation of a Mental Health Association. The response was most gratifying. Thus encouraged, the Standing Committee proceeded and the inaugural meeting of the South Australian Association for Mental Health was held on 11 October, 1956, with the Lord Mayor, Mr. J.S. Philips, as Chairman.

In the formation of the Association, I had had great stimulation and support from Dr. Alan Stoller, who by this time had joined the Victorian Mental Hygiene Authority. He gave the inaugural address on the subject: "Society and Mental Health". I also received help from the Chairman of the Authority, Dr. Eric Cunningham Dax, whom I had met at the First International Congress in Psychiatry in Paris in 1950 and later in London., and from Dr. H.F. Maudsley, who was one of the initiators of the formation of the Australasian Association of Psychiatrists (later to become the Royal Australian and New Zealand College of Psychiatrists). All these men were closely associated with the Victorian Council for Mental Hygiene, > which had been founded as long ago as 1930 and regularly held Congresses on Mental Health and published the Proceedings.

Many eminent South Australians accepted appointment to the Council which held its first meeting on 15 November, 1956, under the chairmanship of the President, Sir Herbert Mayo, a Judge of the Supreme Court. I was present as the Executive Chairman. At this meeting an Executive Committee was appointed as required by the Constitution. Also formed was a Promotion Sub-Committee which was required to develop a plan for promoting larger membership. The need for a Programme Sub-Committee was also

expressed; this was left to the Executive Committee. These two Sub-Committees later fused into one, a Programme Sub-Committee.

At the second meeting of the Council on 4 March, 1957, it was reported that the Promotion Sub-Committee suggested that the title for the 1957 Congress on Mental Health should be "Mental Health and Human Relations in Industry". The Programme Sub-Committee suggested that projects which could be considered included refresher courses in psychiatry for nurses, courses for general medical practitioners, and courses covering the inter-related fields of psychiatrists, psychologists and ministers of religion. These recommendations confirmed that the early thrust of the Association was directed towards professional and community education.

By arrangement with Dr. H.M. Birch, the Superintendent of Mental Institutions, the course of 12 lectures given to third year Mental Nursing students, commencing on 9 July, 1957, was made available to general nurses and the Association enrolled 42 trained general courses for the course. The response illustrated the perceived need for such a course. This was the first of three courses of lectures in psychiatric nursing arranged by the Association, the second course being commenced in August 1958 and the third in July 1959. The lectures were given by Dr. B J. Shea¹ (who subsequently ended his outstanding career as the first chairman of the South Australian Health Commission) and in all 103 generally trained nurses attended.

The second Congress on Mental Health was held in the Freemasons Hall from 7-9 August, 1957, the opening address being delivered by the Premier of South Australia, Sir Thomas Playford². The response to these meetings was disappointing and the attendances small. It was decided to concentrate in the future on smaller discussion groups following an address or mental health film.

It was within the context of community education that the Barton Pope Lectures were born. In December 1958, when the need for a Chair in Psychiatry at the University of Adelaide was being discussed³, it was suggested that Professor W.H. Trethowan, Professor of Psychiatry in the University of Sydney, be invited to address a public meeting in Adelaide. Professor Trethowan accepted not only the invitation to give a public lecture but also to spend a week in Adelaide and to report⁴ to the Association his opinions of

South Australia's requirements in the mental hygiene field. Mr. S. Barton Pope⁵, a member of Council and Vice-President of the Association, offered to donate one hundred pounds towards the costs of organising the lecture for which the Council of the University had agreed to make its Bonython Hall available. Later, Sir Barton Pope, as he became, donated one thousand pounds to endow an Annual Lecture. Professor Trethowan thus delivered the Inaugural Barton Pope Lecture on 1 June, 1959, on the subject: "Man's Progress towards the Goal of Mental Health". The lectures became a regular feature of the Association's calendar of activities, becoming associated with and a central point of the annual Mental Health Week. (By 1976, 16 Barton Pope Lectures had been delivered). In July, 1963, it was announced that Sir Barton had donated a further one thousand pounds, making a total of two thousand in all, which was to be invested to provide the funds to defray the costs of the Barton Pope Lectures.

(ii)

Sidney Barton Pope was a leading industrialist who played a major part in the expansion of secondary industry in South Australia. He started his manufacturing business as a young man with a backyard workshop and subsequently founded the Pope Group of Companies with some 3,000 employees.

He played an active part in developing the Meningie-Coonalpyn area of the Upper South East of the State in the early days of trace element discoveries, but also was prominent in the commercial life of the community. He was an active member of the South Australian Chamber of Manufacturers for many years and was President from 1947 to 1949.

Always in the forefront in promoting good employer-employee relationships, Barton Pope was knighted in June, 1959, at the age of 54.

Sir Barton supported and assisted various charitable and patriotic organisations and appeals. This was especially so with the South Australian Association for Mental Health, where he gave me great

encouragement in its formation and advice and material help in launching an appeal for funds, during "Mental Health Year, 1960", to assist the University of Adelaide to establish a Chair in Mental Health. The funds provided for the Barton Pope Lecture were part of this promotion.

In later life, Sir Barton showed great concern for the future health of the Australian community. In conjunction with Sir Macfarlane Burnet, the eminent medical biologist, and Sir Mark Oliphant, world famous physicist and former Governor of South Australia, he established the Australian Advisory Council of Elders. The aim was to draw together retired Australians to make use of their experience and express their concern for the problems confronting our nation and the necessity for responsible leadership and direction.

Sir Barton Pope died suddenly in September, 1983, while on one of his busy missions.

(iii)

In 1963, two other innovations were made to develop community education. On the suggestion of Dr. W.A. Cramond, Director of Mental Health, consideration was given to the holding of a Mental Health Week, just referred to above. The other was the presentation of a Psychodrama. The first of these was written by my wife, Shirley, and me and presented at "Theatre 62"⁶ on 13 February, 1963. This was so successful it was repeated on 29 April by popular request, and the Australian Broadcasting Commission presented the play, under the title, "Trial or Trust", as a discussion, on Channel ABS 2 on 22nd May, 1963.

This development posed a problem for the medically qualified members of the Association. The Australian Medical Association was strongly opposed to doctors "advertising". It was necessary for me, then, to protect myself and others from any form of disciplinary action. I wrote, therefore, as Executive Chairman, to Dr. Richard Oaten,⁷ the then President of the South Australian Branch of the Australian

Medical Association, requesting permission to appear on television and in any public forum on behalf of the Association for Mental Health. The televised production was also very successful. In September, 1963, we had a request from the Australian Broadcasting Commission Manager for South Australia, J. S. Miller, inviting us to prepare four more psychodramas and discussions on different themes for television.⁸ Unfortunately, it was not possible to prepare four psychodramas by the dates suggested in January-February, 1964, and the opportunity was lost.

In 1966, a psychodrama was produced as a "fringe" production of the Adelaide Festival of Arts in Way Hall during lunchtime on 16th March 1966. "The Advertiser" next morning published the following review:

"A prime function of a Festival of Arts should surely be experimentation, and this function was admirably fulfilled yesterday at Way Hall, Central Methodist Building, by a lunchtime Psychodrama, "The Hollis Family".

"The experiment was a resounding success, and, as an unusual Festival fringe activity, could bring recurring benefits to Adelaide.

"The capacity audience's reaction to the one act play and question session was so obviously one of interest, that a spokesman for the South Australian Association for Mental Health (which arranged the experiment) said other Psychodramas would be staged during Mental Health Week.

"The idea is a kind of group-therapy-through-theatre, in which a play is performed and then dissected for its psychological and sociological implications by a panel of experts and questions from the audience.

"Yesterday's sophisticated and intelligent play about a family's inner tensions, was skilfully performed by Adelaide actors, Audrey Stern, Neil Lovitt and Sue Lawrence.

"On the panel were the professor of psychiatry at the University of Adelaide (Professor W. A. Cramond), the Director of Mental Health Services in SA (Dr. B.J. Shea) and Miss Mary Smith, formerly a Government psychologist and now in private practice.

Psychodramas, as conceived by us in the Association for Mental Health, were quite short playlets around a mental health theme. They were open-ended; that is they presented some family, interpersonal, emotional situation, which led up to a climax and then stopped. No solution to the problem, no answer to

any emotional dilemma was given. This was left to discussion by a panel and by the audience, with a free-flowing expression of ideas. Audience participation was usually excellent.

Writing a psychodrama was great fun. After the first, a group of us would get together to decide the theme, what characters would take part, and how the plot would develop. Then we would sit around a tape recorder, put all these ideas into it and even "talk" out the possible dialogue, and suggest the climax desired. The tape was then transcribed and the basic ideas given to a script writer to put into a form suited to the actors who would take part. All the participants, from the first group who talked into the tape recorder, to the script writer, to the players who brought the script to Me on stage, and the panel who helped with the discussion, gave their time and talents without fee. The extent of the voluntary effort was truly remarkable. Unfortunately, the time and effort required to dream up the plot, write it and then involve sufficient people to present it proved too much and the last psychodrama was played in 1970. It was put on, as part of Mental Health Week in the South East of South Australia and was played at Naracoorte, Millicent and Mount Gambier.⁹ Dr. W.A. Cramond was a member of the panel that opened the discussion for the first and a subsequent psychodrama.

The first reference to Bill Cramond in the minutes of meetings of the Council of the South Australian Association for Mental Health is on 10th April, 1961. Also, there is mention that I reported that I had had a letter from Dr. Kenneth Cameron¹⁰ of the Maudsley Hospital, London, stating that he would be in Adelaide in the June and would be available for lectures. The Association did arrange a most successful meeting on 30th June which was attended by approximately 60 psychologists, teachers, social workers, nurses from the Adelaide Children's Hospital and members of the Council. The point of this story is that it was during this visit that the Association gave the dinner of welcome to Dr. W. A. Cramond, to which Dr. Cameron was invited and to which Bill Cramond referred in his reminiscences about his early contact with me and the Association. He also attended the meeting of the Council on 10th July, 1961 where he was welcomed as the newly appointed Director of Mental Health and Superintendent of Mental Institutions.

In October, 1958, I reported to the Council of the Association for Mental Health on discussions that an ad hoc sub-committee had had with the then Superintendent of Mental Institutions, Dr. H.M. Birch, on how the Association could co-operate with the mental health department in setting up clinics, improving out-patient facilities and working to overcome the shortage of trained psychiatrists. It was felt that the biggest single necessity was the training of more psychiatrists, and that the Association could assist by working for and seeking the approval of the Medical Faculty for the establishment of a Chair of Psychiatry at the University of Adelaide.

At the first meeting of the Council in November, 1956, it was agreed that steps be taken to seek membership of the World Federation for Mental Health. The application for Affiliate Membership of the W.F.M.H. had been approved by October 1957. In July, 1958, a notice was received from the Foundation suggesting that 1960 be marked as "World Mental Health Year". The idea was taken up by the Association and at the Council meeting on 1 December, of that year, Dr. Clifford Jungfer¹¹ suggested that one of the Association's aims for 1960 could well be the establishment of a Chair in Psychiatry at the University of Adelaide. The seed of this idea rapidly took root so that by the time Professor W.H. Trethowan came to Adelaide and delivered the first Barton Pope Lecture in June 1959 much work had been done.

Approval for the establishment of a Chair in Psychiatry was obtained from the Dean of the Faculty of Medicine, Dr. K.S. Hetzel. Sir Barton Pope, Dr. Hetzel and I waited on the Vice-Chancellor, Mr. (later Sir) Henry Basten. The outcome of the meeting was that, if the approval of the Council of the University were obtained in November, it should be possible to proceed with plans to establish the Chair provided sufficient funds were raised to cover the financial requirements for five years. The estimated sum required for this purpose was forty-five thousand pounds. Put differently, it meant that the University had approved of the establishment of a Chair of Psychiatry as part of its development plans; these plans could be brought forward by five years if the Association could raise the money for the necessary funding. Sir Barton, Dr. Hetzel and I also met with Dr. H.M. Birch to learn of any difficulties that may have to be overcome to enable a Professor of Psychiatry to use hospital beds for student training in the Mental Institutions. Dr. Birch expressed his willingness to co-operate in this matter. Representatives of "The News", the afternoon

daily newspaper in Adelaide, had met with Professor Trethowan, the Secretary (John Potter) and me and displayed a most encouraging willingness to help launch an appeal to raise the necessary funds early in 1960.

At that time, too, further, encouragement was received when the Secretary reported that the Public Relations firm of Webb-Roberts McClelland Pty. Ltd. had offered its services without reward to act as public relations officers for the Association. Excellent service was given in the form of press and radio cover in connection with the visit of Professor Trethowan and other distinguished speakers and valuable advice suggesting the most suitable way of promoting the aims of the Association. The help given by this firm, and especially that of its Managing Director, Mr. R.W. Griffiths, was invaluable during the actual Chair in Mental Health appeal.

The change in name from "Psychiatry" to "Mental Health" was my suggestion, but was supported by Bill Trethowan. In his report to the Association after his visit from 27 May to 7 June, 1959, Professor Trethowan wrote:

"On the whole I am inclined to favour the establishment of a Chair of Mental Health, rather than a Chair of Psychiatry. Though to some the difference may appear to be slender, it is becoming increasingly clear from modern developments that the major part of a psychiatric professor's work should be directed towards the field of prevention and (in the case of those who have broken down) towards furthering community care. The applications of the principles of public health have so much proved their worth that with the disappearance of most of the major epidemic disorders, the mental health problem has begun to loom very large indeed....."

"Even though a Chair of Mental Health rather than a Chair of Psychiatry, the same responsibility for giving medical students adequate training in psychological medicine would exist."

By October, 1959, an appeal committee had been formed. It was decided that the most opportune moment to launch the appeal would be in May 1960. In December, it was resolved that a letter, signed by the President, be sent to the Premier of South Australia, Sir Thomas Playford, inviting him to become Patron of the Committee of Sponsors that would underpin the appeal to be launched for the purpose of establishing a Department and Chair of Mental Health at the University of Adelaide. The Premier accepted the invitation.

In April, 1960, I was able to report to Council:

"The Appeal Committee has held four meetings to attend to the comprehensive details necessary in launching an appeal of the magnitude required to raise forty-five thousand pounds. A Committee of Sponsors, under the chairmanship of Mr. Keith Benger, has been formed and the Association is most fortunate to have the support of the thirty-six prominent citizens who have agreed to act on this Committee¹². The Committee of Sponsors will meet at 4.30 p.m. on Thursday of this week in the Light Room at the Adelaide Town Hall to hear why it is so essential for a Chair in Mental Health to be established in our own University and to learn what steps are contemplated for the public appeal. Feature articles will appear in the Press during April and personal letters, in folders containing information of vital interest, will be distributed to 5,000 business houses and individuals just prior to the formal opening of the appeal by the Lord Mayor on Monday, 2nd May. The list of the names of Sponsors, together with the information to be published, are available if the Council would care to hear them".

It was both fortuitous and fortunate that Dr. J.R. Rees visited Adelaide from 4-7 April, 1960, and delivered the Second Barton Pope Lecture, entitled "Mental Health and Our Contribution to the World Community". Jack Rees, as he was popularly known, was the First President of the World Federation for Mental Health in 1948 (and largely its founder) and from 1949 its Director. The lecture virtually opened the publicity campaign in connection with the appeal. It was pleasing to note that the Vice-Chancellor of the University of Adelaide was in the Chair.

By July, 1960, the Appeal Fund, less expenses, stood at approximately twenty-one thousand five hundred pounds. The Vice-Chancellor agreed to place the position before the Finance Committee of the University at its next meeting. The donations had been invested because it had been ascertained that the University would require the Association to reimburse actual expenditure incurred only at the end of each year. On this basis, the Association already had sufficient funds to meet expenses for the first three years. By September, the appeal fund had reached approximately twenty-four thousand three hundred pounds. The Council of the University had set up an appointments committee charged with the task of establishing the Chair in Mental Health. Applications for the post of Professor of Mental Health closed on 28 February, 1961.

Dr. David Maddison from Sydney applied and was appointed to the Chair at the University of Adelaide, but never took up the post. Professor W.H. Trethowan, who held the Chair of Psychiatry at the University of Sydney, was invited to take the Chair of Psychiatry at the University of Birmingham. When he accepted this, the University of Sydney was left without a Head of Department half way through a Course for the Diploma of Psychological Medicine. So they got in touch with Adelaide and asked if they would free David Maddison to take over the Chair. They did, and Adelaide was left in a rather embarrassing position. The Association now held twenty-six thousand five hundred and thirty pounds towards establishing the Chair.

The University re-advertised the position. It was also announced that Professor H. N. Robson, Professor of Medicine at the University of Adelaide, would proceed abroad to interview possible candidates. Regrettably, Professor Robson returned to Australia without being in a position to recommend any applicant for the position. Five Chairs in Psychiatry were vacant in England and the Universities of Melbourne and New South Wales were also seeking professors. Thus it came about that the most suitable person was found in Adelaide, and Dr. W.A. Cramond was approached to take the Chair.

Now Bill Cramond had never thought seriously about academic work nor becoming an academic. When he was working at Kingseat Hospital in Aberdeenshire, which eventually became a teaching hospital for psychiatry in Aberdeen University Medical School under Professor Malcolm Millar, he had become a

clinical assistant. Though it was a honorary post, it meant that he did some teaching of medical students. In the Department of Psychiatry, he would interview patients behind a one-way screen and then discuss his findings with Professor Millar and the students. So, as long ago as the early 1950's, he was doing medical school teaching. Then Malcolm Millar persuaded him to do some research. The Board of Management at Kingseat Hospital gave him permission to do half-time clinical work, and the Medical Research Council paid the rest of his salary. He worked half-time in the Department of Obstetrics and Gynaecology at Aberdeen University, under the supervision of Professor Sir Dougal Baird, and did an M.D. thesis on his original work on the psychological aspects of uterine dysfunction. Baird was an outstanding researcher, and Cramond had a very thorough training.

When he moved to Woodilee Hospital as Superintendent, he wrote a joint chapter with Malcolm Millar for the 5th edition of Baird's Textbook of Obstetrics and Gynaecology called "On psychiatric (or psychosomatic) obstetrics". That was his first publication; but then the work he had done for his M.D. thesis was published in "The Lancet".

While at Kingseat Hospital, chlorpromazine (largactil) had been introduced. That was followed by a whole lot of first cousins to chlorpromazine. May and Baker, the drug firm, was particularly interested in trying out some of these in clinical trials. Cramond did some of the original work at Kingseat, and, when he went down to Woodilee, began organized double-blind clinical trials of thiofluperazine. One of his early papers was a chapter in a book by the Professor of Psychological Medicine at Glasgow University, Ferguson Rodger, called "Topics in Psychiatry". His chapter was based on the clinical trials with phenothiazines. This work kept his research interests alive and, when Woodilee became a teaching hospital for Glasgow University, he was granted Senior Lecturer status.

Professor Alexander Kennedy died in 1957/58. Cramond was encouraged by some very senior people to submit an application for his Chair at Edinburgh University. He was unsuccessful. However, when he came to Adelaide, the encouragement he had received helped him to realize that, if the mental health services reorganisation he was trying to initiate were ever to succeed and retain its success over the years, something would have to be done about teaching psychiatry and getting good young doctors into key

positions, for they would be the ones to give the lead. He was therefore delighted with the Mental Health Association's idea of funding a Chair and supported it strongly,. But, at that time, he claimed, he had no other thought in his mind.

Cramond was half-way through a four-year contract with the Hospitals Department when he was invited to take the Chair in Mental Health at the University of Adelaide, towards the end of 1962. He had also been invited to take the Chair of Psychiatry at the University of Melbourne. He informed the Director General of Medical Services, Dr. J.W. Rollison, about the two offers and stressed that he would prefer not to leave Adelaide. The position was a difficult one for Dr. Rollison and the Public Service Commissioner, Mr. Clem Pounsett. An agreement was reached that he could do both jobs half-time until he concluded his four-year commitment to the South Australian Government in 1965. He accepted this arrangement because he felt it was terribly important to have a professor who could become involved in the teaching of medical students in order to bring people into psychiatry the sooner the better.

(iv)

But it is necessary to return to certain activities that took place in the Mental Health Association, which illustrated the close relationship that developed between it and the Director of Mental Health with mutual benefit to both. In April, 1962, the Secretary advised the Council of the Association that, in response to an invitation from Dr. Cramond, twenty-four members had expressed a wish to be included in parties to visit the State's mental hospitals. The object of the invitation was to permit groups of concerned people to see at first hand the need for improvement in the mental hospitals and to support the Director in his efforts to meet these needs.

The first visit was arranged for Saturday, 14th July, 1962. Prior to that, two meetings of representatives of twenty (20) organizations in the community had been held to consider ways in which to improve the existing mental health services in the State. I had chaired these meetings which had been convened by the

Association. Steps were being taken to encourage members of Parliament to visit Parkside Mental Hospital to learn first hand the need for increased staff facilities, for staff training and for improved buildings. A third meeting of the organizations, held on 31st August, received a memorandum on the prevailing conditions in the State's mental health services. It was resolved to use the memorandum to bring about a better informed community by distributing copies to members of the organizations concerned, to the Premier and Members of Parliament and the Press with an advice that the report was being circulated so that the Government would have public support in the action contemplated.

Further visits of inspection were made in June, 1963, in May-June 1964 and in May-June 1965. These arose out of the meeting of the representatives from the organizations concerned with the mental health services held on 15th November, 1963, where I reported that the Council of the S. A. Association for Mental Health had suggested that, in order that the future work of the committee may be co-ordinated in an effective way, consideration be given to setting up a formal ad hoc committee which would carry on the work already commenced and also assume responsibility for the community education side of the Association's work. Mr. C.R. Lawton¹³ had indicated that he would be prepared to chair such a committee. Thus was established the Community Education Committee, which among other things co-ordinated the publication and distribution of the four memoranda on the mental hospital visits¹⁴. Its formation was formally approved by Council at its meeting on 9th December, 1963.

The meeting of Council held on 7th October, 1963, was a note-worthy one. Mr. John Potter resigned as Secretary to become Treasurer and Public Officer (vice Mr. J.H. Stevens, the foundation Treasurer and Public Officer who had resigned on 8th July, 1963); Miss Helen Hanrahan was appointed Secretary. Mrs. Marion Disney was confirmed as Director of the Citizens Advice Bureau. These three people served the Association loyally and well for many years.

Two examples of the fruitful relationship that I, as Executive Chairman of the South Australian Association for Mental Health, developed with Dr. W.A. Cramond, the Director of Mental Health, are to be found in the areas of the rehabilitation of the chronically mentally ill and the care and training of the mentally retarded (now referred to as the "developmentally disabled").

First mention of a club for patients discharged from the State Mental Hospitals, run by Miss Marjorie Black, was made in the Minutes of the Council Meeting held on 4th December, 1961. Miss Black had written to the Association seeking its support for the Club she had established five years previously. It had 132 names on the roll, met weekly and was attended by approximately 60-80 people. Many of the members lived in boarding houses and obviously looked forward to this weekly outing. Miss Black now felt that it would be better if the Club were administered by a committee which she hoped would be sponsored by the Association for Mental Health. I reported that I had had discussions with Dr. Cramond who felt that satisfactory co-ordination with the mental hospitals was vital in this kind of venture and that the proposed involvement in the Club by the Association had his full support. By October, 1962, a committee had been set up under the Chairmanship of Dr. W.E. Mickleburgh, a member of Dr. Cramond's staff. The Council opened a bank account in the name of the "Rehabilitation Committee" and gave it authority to conduct clubs for discharged mental hospital patients where and when it was considered necessary and practicable, to conduct a survey to determine the social conditions and needs of discharged patients and to make recommendations in regard to legislation considered desirable in the interest of such people. Miss Black was invited to become a member of the Council of the Association.

The Rehabilitation Committee and the Community Education Committee both became involved with the standard of accommodation available to discharged patients from mental hospitals on their return to the community. In its report of 21 February, 1964, the Community Education Committee recommended that, "in view of the low grade boarding houses being opened up for ex-mental patients and the unfair treatment they receive", the Executive Committee bring before the Government Authorities the need for inspection of these boarding houses. On 13 April, 1964, Miss Black reported that State authorities were now interested in this subject and an investigation had been made. It is interesting to note that this investigation and report had been made by Dr. W.E. Mickleburgh at the request of Dr. W.A. Cramond, who, as far as he can recall, was alerted to the situation by an article in the weekend newspaper by Miss Helen Caterer, a journalist who probably got her information from one or both Committees of the Association. Suffice to say, the outcome was satisfactory. Boarding houses were surveyed, conditions were laid down, and those

that met the criteria agreed upon between the managers and Dr. Mickleburgh's committee were licensed as "Psychiatric Rehabilitation Hostels" under the Mental Health Act.

The Rehabilitation Committee went from strength to strength. In July, 1964, Miss Black and Dr. Mickleburgh put forward the suggestion that a permanent Club premises be established. This was approved by Council and the Committee was asked to explore the possibility. By April, 1965, the Rehabilitation Committee, through Miss Black, was able to report that an option had been taken on a property on King William Road, Wayville. A member of Council (Dr. Marjorie Casely Smith) made an interest-free loan to the Association to permit the purchase and The Savings Bank of South Australia granted the Association a mortgage. The Council gave authority for the use of the Association's Seal in any documentation that was necessary. This property became known as "Marjorie Black House". It is still in use.

"Marjorie Black House" was officially opened by the Minister of Social Service, Mr. Don Dunstan, on 19 September, 1965. A Marjorie Black House Committee, composed of volunteers working at the Centre, was set up and by its sustained efforts paid off the loan from Dr. Casely Smith and later the mortgage on the house. As Director of Mental Health Services, I did manage to obtain a grant from the Commonwealth Department of Health, under its Community Mental Health Centre programme, for extensions to the property. However, apart from this, the House was completely self-sustaining and never imposed on the funds of the Association.

The efforts of the Community Education Committee were also producing results. The Chairman, Mr. Colin Lawton, advised Council on 14 December, 1964, that the Third Memorandum of visits to Mental Hospitals was ready to be sent out. Commenting on the findings, he pointed out that the Government attitude had changed: the budget had been increased by 13% and building was going ahead. However, staff were still urgently required. In all, it was evident that there was now a greater acceptance of responsibility.

A Fourth Memorandum based on visits to mental hospitals in May-June 1965 was produced. These four memoranda are attached as an appendix to this story.

In the "Minda Lecture" delivered on 10 August, 1963, Dr. W.A. Cramond suggested that there was need for all organisations, both statutory and voluntary, to get together and establish a Committee at which representatives could meet and discuss the special needs of the mentally retarded and what could be done to meet them. He suggested that the S.A. Association for Mental Health would be a proper body to form such a Committee. At its meeting on 9 December, 1963, the Council of the Association gladly accepted this request, contained formally in a letter from Minda Home Inc., as a service it could proudly undertake. The Secretary was instructed to write to the following associations advising that a meeting would be held at the Minda Home Office, 33 Pirie Street, Adelaide, on 18 February, 1964, and asking for two members to be nominated: -

Suneden Mentally Retarded Children's Welfare Association

Minda Home Inc.

Mentally Retarded Children's Association

Education Department

Northfield Mental Hospital

Parkside Mental Hospital

The representatives from the S A. Association for Mental Health Inc. were to be Mr. W. Mansfield and myself.

The Co-ordinating Committee on Mental Retardation, as it came to be called, became a sub-> committee of the Council of the Association, but in a loose sort of way. Many, if not most, of its members were not members of the Association. It was defined by our Honorary Solicitor, Mr. Malcolm Playford, as a "satellite committee". It nevertheless functioned extremely effectively and was a means of bringing together people and bodies concerned with the problems of the care, education and habilitation of mentally handicapped persons, who had not before talked together, shared experiences, identified areas of need and sought to try and remedy deficiencies.

For the record, the representatives of the organizations appointed to the sub-committee were as follows:

Suneden Mentally Retarded Children's Association

- Messrs. B. Kelly and J. Lennell

Minda Home Inc.

- Messrs. D. Waterhouse and D. Crawford

Mentally Retarded Children's Association

- Messrs. C. Watt and J. Hayes

Education Department

- Messrs. L.S. Piddington and J.D. Gunton

Northfield Mental Hospital

- Dr. J.S. Coverton and Mr. J. DeKuyer

Parkside Mental Hospital

- Matron M. Birch and Dr. Barbara Meyler

S. A. Association for Mental Health Inc.

- Dr. W. A. Dibden and Mr. W. Mansfield.

The President was Mr. David Waterhouse; the Deputy-President was Mr. Colin Watt, and the Secretary was Mr. Brian Smith.

Meeting approximately monthly, this committee did a tremendous amount of work in co-ordinating and collating information about the work carried out by each of the organizations. A Directory of Services for the Mentally Retarded in South Australia, printed in 1967 with a revised reprint in 1970, filled a great need in making known the availability of public and supportive services. Requests for this Directory were received even from other States.

The exchange of information and the opportunity for free discussions permitted concerted action when the need arose, as, for example, in submissions to the committee of Enquiry into Education in South Australia, concerning Pre-School Education, Transport Services and Education facilities for the Mentally

Retarded, and Training or Re-training for work and employment; and to the Committee of Enquiry into Health Services in South Australia.

Through the South Australian Association for Mental Health, the Committee requested that a Standing Inter-Departmental Committee for the Care of the Mentally Retarded be set up. As President of the Association, I wrote to the Premier of the day, Mr. Steele Hall, M.P., clearly setting out the ideas behind this request

The Government accepted the recommendation and a Standing Inter-Departmental Committee was formed consisting of nominees of the Ministers of Health, Education and Community Welfare.

This all took place during 1970. At the same time, the Co-ordinating Committee was giving thought to the formation of a South Australian Association for the Mentally Retarded, foreshadowing the dissolution of the Co-ordinating Committee. The South Australian Association for Mental Health was in favour of such a move and convened the meeting on 6th June 1971 at which the formation of the new association was considered. Thus, by a process of growth and evolution, the Co-ordinating Committee for Mental Retardation was superseded by two new bodies, the Consultative Council and the South Australian Association for the Mentally Retarded. The latter still exists. The Consultative Council can be considered to be the fore-runner of the Intellectually Disabled Services Council, established in about 1983.

This progression also demonstrates the evolution of my own involvement in the field of mental retardation and my link with Bill Cramond, the Director of Mental Health.. The Co-ordinating Committee arose out of a suggestion made by Bill Cramond in his 1963 Minda Lecture. As Executive Chairman of the South Australia Association for Mental Health, I assisted in its initial meeting and to establish it as a Subcommittee of the Council of the Association. I represented the Association at its meetings in the early years of its development. As President of the Association, I wrote to the Premier recommending the establishment of a Standing Inter-Departmental Committee on the Care of the Mentally Retarded and a Consultative Committee which would replace the Co-ordinating Committee. As Director of Mental Health Services, I was appointed to the Standing Inter-Departmental Committee, with Gordon Bruff from

Community Welfare and John Steinie from Education. By this time, of course, I had resigned from the Coordinating Committee. But, I had also been made a member of the Board of Management of Minda Incorporated by the Minister of Health; and, as such, was appointed by the next Minister of Health, Jennifer Adamson, to the newly proclaimed Intellectually Disabled Services Council. For someone who had never taken a great interest in intellectual retardation, Bill Cramond certainly had a significant influence on my life by his suggestion in 1963.

Bill Cramond also started something when he suggested in April 1963 that the Association for Mental Health take responsibility of the arranging of an annual Mental Health Week. As Executive Chairman, I took this suggestion up with enthusiasm and the Association organized the first week in August 1964 on the theme "Towards Mental Health". It dealt with early treatment. With practical assistance from the Mental Health Services, visits to hospital Health Services, visits to hospitals, talks, films and discussions were interest in the community. As a result a Mental Health week has been arranged practically every year ever since. From the beginning, the Barton Pope Lecture, inaugurated in 1959 and already referred to, has always been a focal point of the Week and the subject of the Lecture has usually been built around the theme. I was privileged to deliver the Fifteenth Barton Pope Lecture in 1975.

I cannot emphasize too much the importance of the relationship that Cramond built up with me and the South Australian Association for Mental Health and the way in which he could use the Association for the benefit of the mentally ill and the mentally handicapped in this State. He never felt he was being disloyal because he never did anything without having briefed the Minister, briefed the Director General of Medical Services, Dr. Rollison, put in papers to show what should be done. His advice was on record. Then, having done that, he considered it was quite proper for him to say to bodies like the Mental Health Association: "You might like to draw to the attention of Members of Parliament what, in the ideal world, is required or what should be done".

Cramond's attitude was quite clear. As a public servant, his loyalty was to the Department and through that to the Minister. But, he also had a duty to the patients and the families of the patients. If the Minister and the Director General of Medical Services were briefed and, after sufficient time, nothing happened, then it seemed to him that he could put on another hat (that of a clinician, with a responsibility to the patients, who was trying to open up a closed institution in order to help the patients) and be at liberty to talk to social groups like the Association for Mental Health and Rotary Clubs and church groups, to let them know what he was planning to do, why he was planning to do it, and what their role might be in understanding the problems of the mentally ill in society. I had complimented Bill Cramond on the way he had opened the hospitals for visits by groups who came to constitute the Community Education Committee of the South Australian Association for Mental Health. The four memoranda produced by this group are collected and attached as an appendix. He responded by saying it was to the benefit of the patient, it was the way by which he was able to express the needs of the patients and the staff through an important lay body who could approach politicians directly and who could say things in public that he could not say necessarily as bluntly or as firmly. He thought it worked very well; for he always felt it was important that the Minister was briefed thoroughly before stirring the pot with the other hand.

Dr. W.A. Cramond recalled that, when he stopped being Director of Mental Health in 1965, the Public Service Commissioner, Mr. Clem Pounsett, beamed at him and said that he had always known that he ran with the foxes and hunted with the hounds; though he had never stopped him from doing it.

CHAPTER 4

CRAMOND

Before the War in 1938, Cramond and a very close friend decided that they wanted to go overseas and were interviewed by the West African Trading Company with a view to training to become farm managers in West Africa. Cramond was persuaded by his father, on advice from some friends, in particular an agricultural economist, that it would be better if he got a degree first. So he started a degree in Bachelor of Science and Agriculture. He did two years of agriculture. By this time the retreat from Dunkirk had just happened, so he joined up and stopped University. Eventually, he went to the Indian Army and, while in India, developed a bad attack of poliomyelitis. It was while convalescing that he realised he would not be able to follow the plough, and wondered what alternative he could take. He became a medical student. But let Bill Cramond tell in his own words, as he told it to me, how he got into psychiatry, quite by accident:

"I wrote in an almost flippant way to my parents, wondering what I was going to do when I came back (from India) and said that I might as well be a doctor; I had been at the receiving end so long. When I arrived back in Britain, in Aberdeen, in September/October 1942, I discovered that I was a medical student. My father had gone to see the Dean of the Medical Faculty, Sir David Campbell, who knew me because I had played rugby for the University first 15, and was a rugby blue. He was a great supporter of the rugby team, so there was no problem. The "old boy" network worked very effectively and I did a very gentle first year in medicine, doing only medical physics because my chemistry, botany and zoology were carried over from agriculture.

When I qualified, I did a house job with the Professor of Medicine, Sir Robert Aitken. This was disastrous. I always knew my left hand, which had been paralysed, was suspect for holding forceps for any long period of time. I had to get help to put up drips. It was all pretty disastrous.

Looking back, I realise I had high levels of anxiety during that time. Aitken was a very detached, somewhat aloof man who was interested in the scientific approach to medicine. He almost got it to the stage that he made a diagnosis in his office by ruffling through all the results; by the time he saw the patient, it was a foregone conclusion what you were dealing with. Having been at the receiving end for so long, it seemed to me that this was not the medicine that, as a patient, I thought was required".

So Cramond did a year in general practice in a place called Clackmannan. This was a little mining town bang in the centre of Scotland, quite near Stirling where he was later to work. There he, as he put it, "made all the mistakes that the young doctor just out of the egg does". He learned how little he knew about human beings. Then, a pretty young lady with back pain made a suicidal gesture and he took her to see the great Sir David Henderson, of "Henderson & Gillespie" fame¹ Henderson spent ten minutes with the patient and half an hour with him, and was clearly amazed that he didn't know hysterical behaviour when he saw it. So Cramond thought: "Well, I really can't have this going on, I must learn something about human beings".

As a student, Cramond had been very attracted to a man, Malcolm Millar, who later became Professor of Mental Health in Aberdeen. He had just come back from the forces when Cramond was in final year medicine, and was like a breath of fresh air. Until then, the teaching of psychiatry had been the traditional teaching at the circus of the local mental hospital. The local Medical Superintendent demonstrated very psychotic people and put them through their paces in almost a theatrical way. Anybody with any sensitivity said: "My God, that's not for me". Millar brought a whole new vision of what psychiatry was about. Because Cramond was ex-service, Millar took an interest in him. When Cramond phoned him and told him what had happened he advised him that there was a vacancy at a mental hospital called Kingseat. He applied, was interviewed and appointed.

Bill Cramond already knew something about Kingseat. When he was at school, he used to go to the hospital and play against patient and staff teams at football and cricket. During the War, all the patients had been evacuated and the 800 bed hospital became a Royal Navy hospital. So, when Cramond went

there, there were 50 patients and a staff of three. As the hospital gradually filled up to its 800 maximum, he progressed, over the next seven years, from Senior House Officer to Registrar, Senior Registrar, Consultant, to Deputy Superintendent. The hospital became a teaching hospital for Aberdeen University, and a very active, progressive centre for psychiatry in the north-east of Scotland. Millar was, of course, the Professor. This is where Cramond's training in psychiatry was done.

When Cramond first joined the staff of Kingseat, the Superintendent, Scott Annandale, was old (he retired about three months after Cramond got there) and the Deputy Superintendent was another young man back from the forces called Adam Milne. Cramond described him as "a quite extraordinary, charismatic sort of figure". He had been in the war and was psychiatrist to the 14th Army. He was extremely interested in questions of morale and what the Army used to call "man management". It was through him that Cramond came to see the mental hospital rather as an army battalion, with the Superintendent being the Commanding Officer, the Registrar being the Subaltern or Company Commander, the Charge Nurse the Sergeant Major and the patients the troops, the private soldiers. Just as in the Army setting, you looked after the troops, saw they were fed and watered first, so in the same way you looked after the patients. The lines of communication were similar. It was hierarchical, certainly, but it was all to do with keeping the "troops" in good order; it was to do with morale and managing groups of people. This was the sort of background way that Cramond felt was the way to keep a mental hospital running.

Cramond learnt a lot from Adam Mime, from Malcolm Millar (who had had an analysis under Fairbairn and so was interested in object relations theory) and from Sir David Henderson. The latter, as a young man at the Phipps Clinic in America, had come under the influence of Adolph Meyer. They all had a very great influence on Cramond. His psychiatry was eclectic but very much based on the psychosomatic approach.

During his seven years at Kingseat, Cramond did his training and obtained the D.P.M. in London. Then the time came for him to make a decision about moving. Adam Milne was not very well and there was a question whether he should stay on at Kingseat. He decided not to. When the job of Physician-

Superintendent at Woodilee Mental Hospital came up, Cramond applied, was interviewed and appointed. He left Kingseat to join Woodilee in November, 1955.

The experience he gained at Kingseat stood him in good stead at Woodilee. When he had gone to Kingseat, there were only 50 patients; when he left, there were something like 750, because the others had all come back. So he had the business of seeing them to the wards, of settling people down, of building up staff again, of training staff. He was actively involved in all these things and was ready to take these ideas of administration, of morale, of being involved with the staff at all sorts of levels, with him to Woodilee. As Kingseat was a country hospital, he had spent a lot of time with the staff in social ways (he used to play cricket for the staff team) and got to know people.

When Cramond arrived at Woodilee, the hospital was full, overly full; there were 1250 patients, rather more men than women. Some of these patients had been in bed for up to 25 years. A very poor, limited medical staff had no understanding of the intoxicating effects of overdoses of potassium bromide, a standard sedative used at the hospital. He had bromide levels done and discovered over a dozen cases of bromism. Once the drug was stopped the patients got better. Some had been ill for years. Electroconvulsive therapy was rarely done; it had never been done with the proper precautions of an anaesthetic and muscle relaxant. That was introduced.

The hospital was run by the union. If there is no leadership the unions will step in to fill the vacuum. As the unions were extremely conservative bodies, it was a question of getting them on side, helping them to understand that he would do what he said and carry the can if there were any accidents; and that meant that nobody would lose their job if a patient absconded because they had started to unlock doors.

"We worked at this for five years. Ferguson Roger, who was Professor of Psychological Medicine at Glasgow at the time and who had been a part-time Commissioner on the Board of Control at an earlier stage in his career, was extremely helpful and supportive. After about three years we became a teaching hospital of the University of Glasgow and started to do research. In fact, one of my first papers was a chapter in a book edited by Bob Mowbray and Ferguson Roger

on "Topics in Psychiatry". This was a review of simple, double blind clinical trials we had done at Woodilee with some of the early tranquillizing drugs. The hospital was slowly opened up, staff were attracted and the nurses were encouraged".

Cramond found his experience with the unions totally new and quite shattering. Many of the staff had as children been brought up during the days of the great depression of the mid-1920's and early 1930's. They were fairly anti-authority and suspicious of authority. He found it difficult to communicate with them and had to work very hard to try and get his ideas across. However, these experiences were a great help for later on because he learnt what he could do and what he couldn't do and not to be too disheartened when he didn't win a battle, for he knew there were things that he could not change. So his perspective widened. He knew he had to be tough but to know when to be tough; to try to develop situations where he was able to do a trade-off.

One way in which he won allies was his decision to break down the large wards at Woodilee into smaller wards. This created more opportunities and more promotional positions for young, active, keen men and women in the nursing profession.

The group that were promoted were very much on side, or the majority were, and they were able quietly to tip him off as to what the union was cooking up next, so that he had the chance perhaps to get one or two steps ahead.

He was also able eventually to persuade the Board of Management that a Catering Officer would be a good thing. When he went to Woodilee, he found that all the ambulant patients went to a huge, central dining room, where the meals were dull and predictable. He pointed out that this was a pitiful situation, that a Catering Officer would have the skills and knowledge to train cooks and that better meals and better ways of serving meals would be the result.

Cramond was able to attract medical staff down from Aberdeen. Four people who had worked with him at Kingseat came down and worked in Glasgow. One of them followed him as Superintendent;

another, Bob Davidson, became a consultant and interested in geriatrics, and was able to develop the geriatric side of the hospital. While he was, as it were, "revising" Woodilee, he developed a link with a little general hospital in the Cowcaddens which was a very slummy place in north Glasgow. He did clinics at this little general hospital, the Western General Hospital, popularly known as Oakbank Hospital, because many of his clientele came from that district of Glasgow. It was there that he met Ferguson Anderson, later Sir Ferguson Anderson, who was the first Professor of Geriatric Medicine in the United Kingdom with his Chair at Glasgow University. They became friendly and used to collaborate. As Anderson was building up his geriatric service in Glasgow, Cramond would take his difficult geriatric patients and he would place some of his elderly patients who, though perhaps still mildly demented, were no longer a behavioural problem. This experience made Cramond aware of the problems of an aging society in terms of psychiatry and the need to have close working relations with geriatricians.

All these learning experiences prepared Cramond for his coming to Parkside Mental Hospital in 1961. As he put it: "One had a better sense of priorities based on previous experience. You knew what you could do quickly and what you had to wait to do; that it would come all right in time".

CHAPTER 5

THE CRAMOND REPORT

On 30th October, 1961, Dr. W.A. Cramond addressed a report to The Honourable Sir Lyell McEwin, Chief Secretary and Minister of Health, for South Australia.

It was a description of "The present mental health services of South Australia with recommendations for the future". In this lengthy document, Dr. Cramond pointed out that modern psychiatric care now emphasised the fact that the hospital admission is only one part of the total treatment situation. The aim, all the time, was to return the patient to home and to work and to support him there using, if necessary, hospital staff and resources. By contrast, the mental hospital psychiatrist, alone of all doctors, had the unfortunate task of locking up his patients; and this in spite of the fact that about 80% of all mental hospital admissions could safely be treated as voluntary patients and were not a source of danger or nuisance to the public.

In order to discuss the present situation in South Australia and to make recommendations for future action, Cramond dealt with the subject under various headings. With regard to Mental Illness and Mental Deficiency, he observed that the mentally retarded (intellectually subnormal) and the mentally ill were grouped together in the same hospitals, in spite of the fact that these two groups posed entirely different problems. The effects of the existing legislation in South Australia, which grouped both mentally ill and the mentally retarded together, would not have been so marked if the hospitals had been so laid out as to allow proper segregation of the two distinct groups. Unfortunately, within the hospitals there was a lack of definition and classification. Among the mentally ill there was no real classification by age or by social

behaviour. Among the intellectually subnormal there was no proper separation either by age or degree of feeble-mindedness, which made training impracticable.

To promote the early treatment of the mentally ill, Cramond proposed the development of out-patient departments, which would act as screening centres for early cases, as treatment facilities for those who could live at home, and to permit adequate follow up after the patient had been discharged from inpatient admission.

He also proposed to divide the metropolitan area and the State into two main catchment zones for the purpose of psychiatric out-patient and in-patient services. The course of the River Torrens would be the dividing line. Plans were already advanced for a small out-patient unit to be built at Enfield Receiving House. It was recommended that a Psychiatric Out-Patient Department be established in the ground floor of the Nurses' Home at Parkside. Because of the modern tendency to live out, away from their place of work, this Nurses' Home, of modern construction and built in 1952, was being only half used. The ground floor could be simply "detached" from the rest of the building, where the nurses lived, without any loss of amenity or privilege. Cramond proposed that the doctors who were already staffing Parkside, Northfield and Enfield would do sessions at the two Clinics. He also envisaged that psychiatrists in private practice could be encouraged to work there on a sessional basis for the usual fees, as could the Professor of Mental Health at the University if he so wished. In order to integrate psychiatry with general medicine, the secondment of Mental Hospital psychiatrists to do out-patient sessions at The Queen Elizabeth Hospital and Royal Adelaide Hospital should be encouraged.

Dr. Cramond described the aim, the benefits and the advantages of the Day Hospital. "The purpose of the day hospital is to deal with patients who are at the half-way in or the half-way out stage". He recommended that steps be taken at once to obtain a suitable building in central Adelaide for this purpose.

Cramond then turned his attention to the Receiving House. He pointed out that, at the time of writing, the bulk of new referrals to the Mental Hospitals passed through Enfield Receiving House. About 50% of them were transferred within a few weeks either to Parkside or to Northfield. This made for double

handling of the patients, was upsetting to relatives and was wasteful of doctors' time, particularly when psychiatrists were in short supply. He proposed, therefore, to make two separate admission zones for the State as previously described. Patients from south of the River Torrens would be admitted to the two new admission wards at Parkside, where there had been on the average always some 30 empty beds. By law, these admission wards would have to be redesignated as a Receiving House.

The plan for patient care thus became clear. The proposed out-patient clinics, which would be attended by all the medical and social worker staff from the three hospitals, would be backed by two receiving houses for the early acute cases, and by the two psychiatric hospitals of Parkside and Northfield for the longer term and geriatric cases. He envisaged that, in time, Enfield and Northfield would become administratively one hospital.

In order to lessen the Parkside stigma, he proposed to use the change in function of the Nurses' Home and the Admission Wards as an opportunity to introduce a new name: for example, he suggested the Out-Patient Department might be called the Eastwood Clinic for Psychological Disorders, and the Receiving House, Cleland House, after the famous earlier Superintendent, if the family agreed. He believed the word "Receiving" in the name was no longer necessary and argued that Enfield Receiving House would similarly become known as Enfield House.

In his report, Dr. Cramond referred, with interest, to an extract from the 1948 Report of the Hospitals, in which Dr. H.M. Birch had said:

"Prior to about 1913, the Parkside Mental Hospital was known as the Parkside Lunatic Asylum, a term which connotes a stigma upon all who were sick enough to require care and treatment therein. There is no doubt that the terms "lunatic" and "asylum" could well be relegated to a past age and it is indeed regrettable that such terms should appear again in common language. It has been suggested that the time has now come to refer to mental hospitals as psychiatric hospitals. I personally would like to see all such terms abandoned in favour of some simple name, for example, "Glen-Burn" without the descriptive terms mental or hospital. Possibly some aboriginal name appropriate to the locality could be suggested".

It is recorded that Mr. T.G.H. Strehlow, Reader in Australian Linguistics at the University of Adelaide, was invited to supply names and the most euphonious seemed to be "RILERA" (meaning peace, quiet; the first syllable was pronounced like the English "rill") so that the change of Parkside to Riler Hospital might have been considered; but if it were, it was never implemented.

The Mental Hospitals came in for trenchant criticism. The majority of the wards housed too many patients for too few staff, he pointed out. To help the hospitals develop an optimal therapeutic atmosphere, it would be essential immediately to break wards down in size from the present order of 90 to 120 to similar units of 40 to 45 patients. This would have two effects: it would encourage promotion among staff, thereby giving incentive to young members who were likely to be promoted only after years of service when they had lost all enthusiasm for their work; and it would allow patients to be seen and appreciated once again as individuals and to be treated as such.

Cramond also pointed out that, in the modern mental hospital catering only for the mentally ill, there were two main classes of patient in addition to the short term or short stay patient. These were the long term or long stay patient; and the geriatric patient, that is the patient over 65 years of age. Each group required a different approach, different staffing ratios and different facilities if maximal help was to be given to them.

In regard to the long term patient, the greatest number suffered from schizophrenia, an illness that, at that time and now, represented probably the greatest challenge to public health in the world. Roughly, every fifth hospital bed in the State would be occupied by a schizophrenic. Although long term patients represented therapeutic failures, it was quite wrong, in his view, to dismiss them as incurable, since spontaneous remission of this illness had been known to occur after even 20 to 30 years. The great problem in dealing with this group of people was to provide them with facilities within the setting of the hospital to keep them in touch with reality and to offset the crippling effects of "institutionalisation". This represented the capacity of an institution to deprive patients of their individuality and hence their dignity. Under hospital conditions in South Australia, Dr. Cramond claimed this was particularly likely to occur. The value

of grouping small numbers of patients in small wards, which had already been referred to, was that the nurse continually saw the patient as an individual and that it allowed the patient to make as many personal decisions for his own actions as possible. It was also important that these long term patients be given useful and interesting work to do and that they be provided with a suitable monetary reward for the tasks they did. This would allow the patient to make decisions as to how he would save up to buy himself clothing and so forth. It had always to be kept in mind that the capacities of the long term patient varied immensely.

Along with the need for the long term patients to have decent clothing, was the great need in the hospitals for the patients to have a degree of reasonable comfort and privacy. Cramond made no bones about his view that the living conditions of the majority of the long term patients was a disgrace to any modern State in the early 1960's.

Turning to the Geriatric Patient, he pointed out that this group was large and would become larger as the population aged. Many physical illnesses in old age presented for the first time with an acute confusion, thus bringing them to the notice of the psychiatrist. It was implicit in the treatment of the elderly that they should be kept mobile. This not only prevented the bad effects of a bed regime, but also made the patient happier and fitter. However, to keep people mobile and in order to provide them with the care and comfort which they deserved, a high nurse/patient ratio was required and an active and well staffed physiotherapeutic unit had to be available. Regrettably, he reported, there were no physiotherapeutic faculties in any of the hospitals.

To give some idea of the amount of equipment required to modernise many of the wards, Cramond listed such items as curtains, linoleum, cutlery, the replacement of large bench tables and wooden chairs with tubular steel tables, and appropriate chairs, seating a maximum of four to six patients, a gradual change from uncomfortable and unsatisfactory horsehair mattresses to rubber pillows and mattresses or inner-spring ones, and the provision of lockers at each bedside. He said he had always accepted as a criterion for a reasonable standard the measure: "Is this how I would want my own relatives treated? Are these the conditions under which I would be happy to see them stay?" He regretted that the answer for Parkside, in particular, for Northfield to a lesser degree, and even for Enfield was "No". Much of the

medical and nursing care was of a high and devoted character, but the niggardly facilities and the relative understaffing left much to be desired. So much so in fact that he could not in all honesty advise a friend or relative, or someone whose opinion he valued, to go as a patient to these hospitals.

Dr. Cramond then turned his attention to the Mentally Retarded. The initial point of referral for the intellectually subnormal patient, he wrote, should be ideally a Diagnostic and Advisory Centre, possibly under the direction of the Professor of Child Health at the University. At this small unit, very young children suspected of being subnormal would be seen, while still at a stage when biochemical and nutritional treatment might still be effective. Advice would be given to parents of handicapped children and, in time, it would be a source of information for the voluntary bodies concerned in the welfare of retarded children.

He pointed out that the age range of the mentally subnormal patient varied from the very young of a few months old, right through to the elderly. In general, there were two main groups: the low grade that required a great deal of care and devoted skill in order to keep them comfortable and happy; and the high grade defective who were intellectually dull and backward and who were easily led and because of this very often ran foul of the law for what were usually relatively petty offences. The feeble-minded person took a long time to develop any skill and his training must, therefore, be carried out in a consistent fashion, over a long period of time. The important point, however, was that many high grade defectives were capable of doing a simple routine job and therefore it was economically sound to encourage them by the use of training methods in sheltered workshops within the special hospital. It was important to appreciate that the apparently hopeless, gibbering defectives in the back wards of Parkside and Northfield could be taught under suitable conditions to manage their own personal hygiene at the simplest level or to do routine repetitive industrial tasks at the other.

Dr. Cramond reported that they were in the process of classifying all the hospital patients. It was estimated that there were about 600 intellectually subnormal persons between Northfield and Parkside. He again emphasised that these people were not mentally ill in any way.

Dr. Cramond acknowledged that this problem had been recognised before and he quoted the following extract from Dr. H.M. Birch's Report of 1951 -

"For the long-range plan I have submitted a recommendation for the erection, within the next ten years, of a new hospital devoted to the care and treatment of all types of mental deficiency in children and young adults. This mental deficiency hospital would be concerned with all grades of incomplete mental development including those requiring a number of school teachers on the staff as well as trade instructors, so that by means of special training the maximum number of patients could be equipped to earn their own livelihoods in the community".

He proposed that planning begin at once for a new hospital of some 800 beds for the intellectually subnormal. Since this would be expensive, he considered that a good case could be made out for sending a senior architect of the Public Buildings Department and himself to overseas centres to review and report on modern design and services in such hospitals. The Government did not accept this recommendation, though he was permitted to travel interstate and to New Zealand. This will be referred to later.

The Cramond Report continued with a consideration of the role and training of the psychiatric nurse. It was pointed out that the well trained mental nurse (this included male nurses or attendants in the old terminology) was, and is, one of the key figures in the therapeutic hospital community. In order to be able to have time to understand patients as individuals, it was generally accepted that an overall nurse patient ratio of 1:3 or 3:5 was desirable. From comparable figures, Cramond showed that the nurses in the State mental hospitals were required to undertake more work than was reasonable if good patient care was to be obtained, aimed at the eventual discharge of the patient where possible.

Quite apart from the relative shortage of staff, he drew attention to the equally important problem of training. At the time of the report, the nurse training consisted of some 36 medical lectures over 3 years, with the addition of another 12 on nursing procedures from a senior sister. There were no qualified tutors on the staff and no proper nurse training school. As a result of this inadequate and uninspired training course, the mental nurse felt inferior to her generally trained counterpart. The Nurses Board of South Australia, while acknowledging the mental certificate, took no part in the training, supervision or the setting

out of the course. He stated that the establishment of a nurse training school was a prime necessity in the near future, as was the development of an up-graded syllabus of study. He suggested that, as a start, the first floor of the Nurses' Home at Northfield could be adapted to provide accommodation for the training of some 20 nurses at a time. He also argued that attention would have to be given in the future to the establishment of a training course leading to a State recognised certificate for the nurse caring for the intellectually retarded. This future development would, however, have to wait until the new hospital for the intellectually subnormal was built and had its own training programme.

Cramond then dealt with the need for and the shortage of social workers and occupational therapists. It had been said that if a psychiatric social worker kept four patients out of hospital for a year, she had earned her salary. She did much more than this. Yet, at that time, there was one qualified psychiatric social worker at the Child Guidance Clinic, one qualified social worker at Parkside and one at Enfield and an unqualified, relatively inexperienced worker at Northfield. Few interstate social workers were likely to be attracted to South Australia as the salaries were so low. Cramond presaged the training of Mental Health Visitors when he stated that "in time, when the psychiatric nurses are better trained and are less custodially minded, suitable nurses, both male and female, could be selected and trained by means of an in-service training scheme as welfare assistants to carry out some of the more straightforward social tasks".

Cramond pointed out that there were no qualified occupational therapists working in the Mental Health Services. He recommended the establishment of a cadetship scheme to permit suitable girls to be sent for training, and pointed out that the benefit to the psychiatric services would be out of all proportion to the expenses involved.

Dr. Cramond turned his attention to the psychiatric needs of children. The staff at the Government Child Guidance Clinic were already overwhelmed with work even though they had been functioning for less than a year. He predicted that the Clinic would expand rapidly and increased staff would be required. The lack of a proper in-patient facility for dealing with acutely maladjusted children in the State was a matter of considerable concern. He proposed a residential school for maladjusted children be established in conjunction with the Education Department. Finally, he urged the establishment of pre-psychotic units for

adolescents from the age of 12 years up to the age of 16 or 17. Such adolescent units, usually with a maximum of about 20 beds for each sex for a population of 1,000,000 had been set up in a number of countries. The length of stay was on an average about 9 months. Such disturbed adolescents were being treated in the mental hospitals. Because their numbers were small, they lived in the adult wards. This was most unsatisfactory. He recommended that a suitable house, preferably in a country district quite near to Adelaide, be bought as soon as possible with a view to conversion to an Adolescent Unit. Dr. Cramond argued that such a scheme, with the Child Guidance Clinic as a centre of referral and teaching, backed by a school for maladjusted children and two small adolescent units for the pre-psychotic and early psychotic child, provided continuity of treatment in co-operation with other agencies dealing with children, and would cover the whole range of childhood disorders.

With regard to Forensic Psychiatry, Dr. Cramond proposed to set up a special division within the mental health services to deal with, first, a psychiatric service to the Courts; second, the resiting of a new hospital for the mentally ill offender, (in his opinion, the living conditions for the criminally insane at Parkside were inferior to that at Yatala Labour Prison) and, finally, the problem of the psychopathic offender which was, and still is, one which taxes the Courts, the prison authorities and the psychiatrist. A forensic psychiatrist was the best qualified person to tackle all these problems, and an appointment was a high priority.

Brief reference was made to Research and Legislation. The existing mental health facilities and the relative lack of staff training in all grades, in Cramond's opinion, made research work impossible. Nevertheless, he felt that mention should be made of the need to set up a Research Centre in the future to work possibly in collaboration with the Professor of Mental Health. In similar vein, he drew attention to the fact that the mental health laws had fallen behind medical practice and with community needs, and that, at some point, possibly in about four or five years time, massive amendments to mental health legislation would be required to bring them into line with current thinking.

Regular training courses would be required, not only to train doctors fresh to psychiatry but also to refresh the senior psychiatrists. Only then would the doctors be well enough equipped to deal with the

mentally ill. For this purpose, a working relationship with the Chair of Mental Health at the University of Adelaide would have to be established.

In conclusion, Dr. Cramond reiterated that over the next ten years quiet but profound developments would have to take place in the mental health services to keep faith with the public, who could be expected to demand the type of services he had outlined. All this would require careful and thoughtful planning, not only of buildings, but of administrative and staffing structures, of training syllabi, and, last but not least, of a programme of community education.

The position Cramond occupied was originally that of Superintendent of Mental Institutions; the title of Director of Mental Health was comparatively recent. He considered the linkage was unfortunate and, if continued, would prevent the proper development of State psychiatric services in the future. He argued that he could not mobilise his energies and abilities for the good of the State if he had also to act as Superintendent of Mental Institutions. He considered it essential that he have the time to plan carefully and sensibly for future mental health developments in South Australia, and that the linkage in the title of Director of Mental Health and Superintendent of Mental Institutions should be broken. He recommended that a building be purchased in Adelaide for the development of an office accommodation for the Director of Mental Health and a Headquarters Staff. This would remove the Director from Parkside. This was desirable as there was a tendency to identify him and his work solely with that hospital; and similarly it was difficult for the Director to envisage the equally claimant needs of the other hospitals when he was so close to the Parkside scene.

The Deputy Superintendent of the two Mental Hospitals, and of the Receiving House, were, in his opinion, perfectly competent to run them successfully as Superintendents. Indeed, the move would give them a sense of purpose and responsibility which they lacked. As things stood, they could never be in complete charge of their hospitals, a legitimate ambition for any worthwhile mental hospital psychiatrist.

His plan was adopted.

CHAPTER 6

IMPLEMENTING THE CRAMOND REPORT

Following the receipt of the "Cramond Report", the Public Service Board appointed a small committee to look at the organisation and the staffing of the proposed mental health service. The committee consisted of Dr. W.A. Cramond, Mr. Jack Moule, Secretary of the Hospitals Department, and Mr. Henry James from the Public Service Board. Their report, which became known as "The James Report", recommended that a position of Secretary of the Mental Health Services be advertised and Mr. Howard Lloyd was appointed in March, 1963. He was Accountant of the Hospitals Department at the time and had held this position since October 1960. Prior to that he had, "knocked around the Public Service an awful lot, including 12 years in the country" and had learned a great deal about the Public Service and how it functioned. In those days, the Public Service was an exceedingly rigid organisation. As Lloyd put it: "You really had to know who to go to and to know your way about the organisation; otherwise you were dead. Probably more importantly, you had to know how to get around the system without being caught".

Dr. Cramond acknowledged that, with the Public Service Board, it took an awfully long time to get things done. As a result, he was always looking for short cuts because there was so much to do and he had to keep up the drive, the momentum to overcome the awful inertia that was present in the institution. This was where Howard Lloyd was so valuable because of his knowledge of the corridors of power.

Lloyd described the general public service administration at the time of his appointment as working as a very rigid, complete public service, but one in which anomalies occurred. One such anomaly that bothered him was the fact that persons employed under an award could be employed simply on the approval of the Minister; whereas those who were appointed under the Public Service Act could only be appointed after the Public Service Board had created a position or changed a position or altered a classification and so on. One of the results of this system, of course, was that you could get approval for,

say, 50 nurses in about twenty minutes, because a Minister was always available; but, if you wanted one base-grade clerk from the Public Service Board, it could take up to nine months.

There were, however, ways of getting around the system. One of the things he used to do was to take someone out of a hospital and put that person on a particular job; having done that he would then turn around and apply for the position to be created. This never endeared him to the hospital concerned, though he always took care that one of his other people from the Headquarters Unit was sent to relieve in that hospital during that particular time. He admitted he was never too fussy where he took staff from; on one occasion he took it from the Central Office itself. This was how he acquired Colin Haynes.¹

On his appointment, Lloyd went out to Parkside Mental Hospital to join Cramond who operated from there. At that stage the Mental Health Services did have a building for a headquarters unit. The first building that was purchased for the purpose of mental health service development was the "St. Corantyn" residence on East Terrace. This was planned to be the first Day Hospital in the State. Cramond and Lloyd moved there from Parkside Mental Hospital. Dr. Cramond occupied the big main room in the front of the house, and Howard Lloyd occupied the room alongside it. On the other side of the corridor was a small room which was used as an office for the typist and as a reception room. The first typist was Miss Margot Brown, who came from the Public Service Board and who proved to be exceptionally competent. The three comprised the total Mental Health Services Headquarters staff for some time; that is until Lloyd "acquired" Haynes from the Hospitals Department.

Lloyd recalled that, when he had been appointed Accountant to the Hospitals Department, he rapidly realised that there had been no input of new staff from outside the department for about the last ten years. In fact, he was the first outside appointment that anyone could remember. In his opinion, any department or organisation needed a continual infusion of new blood. So, when Colin Haynes came to the Department and asked about a position, Lloyd thought he would be an ideal person to take on. He had run an agency in the mid-north of the State, had been Secretary of the local hospital and had come to the city for the sake of his childrens' schooling. Lloyd gave him a job in the Hospitals Department.

When Lloyd moved to "St. Corantyn" he soon knew that he would need an offsider. So, he took Colin Haynes with him. He laughingly admitted that he didn't think Jack Moule, the Secretary to the Department, knew anything about it for a couple of months. In the meantime he had Colin Haynes. Eventually he had the position created. Haynes said he didn't want the job. "So I wrote the application out for him", said Lloyd, "and told him to sign it and sent it in, and he got the job. I don't think he regretted it". This was an under-statement, as will be revealed later.

When they occupied the front three rooms at St. Corantyn, the grounds were in a total mess. There was a row of pine trees between St. Corantyn and the place next door. Among the pine trees was a galvanised iron fence. The sheets of galvanised iron must have been about an eighth of an inch thick. They were very thick, very heavy and very old. They originally came from England and were actually ballast in the wheat clippers. They were some of the earliest examples of galvanising that came to South Australia because, at that time, there was no galvanising plant in Australia. The fence was hidden by all the undergrowth and by the undergrowth on the other side of the fence in the house next door. There was also so much "jungle" down the back of St. Corantyn that it was some time before it was known that originally there was a tennis court there. Lloyd said: "It was nearly eighteen months before we discovered there was also a toilet down in the back corner; there was so much rubbish about it. We had an old dustman who was the gardener, and we got patients and staff from Parkside Mental Hospital to help clean up the grounds. I can well remember that Mr. Colin Haynes, who was later appointed to the Mental Health Services in the administrative staff, and myself used to help them to clean up the grounds, by pulling out the trees and clearing the weeds. It was a thorough mess".

The main rooms of St. Corantyn, where the previous owners had lived and entertained, were very well maintained, unlike the servants', quarters down the back. The stables, where the horses and buggies used to be kept, were well built with a brick floor that sloped in towards the centre. There was also a hay loft up top. There was actually hay in it when the Government bought the property. These stables were later converted to a most satisfactory occupational therapy workshop.

The Public Buildings Department was requested to clean up the premises and to carry out renovations. Lloyd recalled that the main renovations were to the toilet area because the toilets and washing facilities were very old and, of course, not at all suitable for a day hospital. Apart from the general cleaning up, the house had to be painted and re-wired. "We were subsequently told that the cost of doing up the place was about the same as the price the Government paid for the house, which, to the best of my recollection, was thirty-six thousand pounds".

Their experience with St. Corantyn demonstrated to Lloyd that Dr. Cramond was very keen on old residences. There was, however, another reason why he adopted a policy of buying residences and converting them: it was the easiest way to obtain new accommodation. In those days you would probably have to wait ten years to have a place built and Cramond didn't have time to wait. Older residences could be converted for a day hospital, for geriatric use or for whatever was needed. He had another policy: it was to be clearly understood by everyone that only the minimum alterations needed were to take place, and on no account was the character of the old residence to be destroyed. Subsequent to St. Corantyn, he bought the Goss' place on Greenhill Road, known as "Carramar", which originally was to have been a hostel for adolescents but became a Community Mental Health Centre as a result of objections by neighbours; a property out at Fitzroy Terrace, Prospect, Sir Mark Mitchell's old home, which became a Child Guidance Clinic; and the house next door to St. Corantyn which Lloyd called "Draper's Hall" but which Bill Cramond later renamed "Moorcroft House". This became the headquarters of the Mental Health Services. It had been owned by the Fairbridge Society which used to bring boys out from England, probably homeless children, with the objective of preparing them for a life on the land. The outstanding feature of this house was the number of bathrooms and shower facilities. One bathroom, leading off the large room which became the Director's office, had two showers over the bath, obviously so that two boys could take a shower at the same time. Another bathroom upstairs, most probably the original main bathroom, was surrounded by mirrors and conjured up erotic thoughts of what might have gone on there. Still, later, a property on Woodville Road was purchased and became a second Community Mental Health Centre, known as "Beaufort Clinic".

When the place adjacent to St. Corantyn was bought, the row of pines and the fence and the jungle of weeds were cleared away. Lawns were planted on each side and new trees along the boundary. The result was a most picturesque one: the trees, old and new, the lawns spreading unbroken from St. Corantyn to the north to Moorcroft House to the south created a beautiful and restful area. Later, when day patients attended St. Corantyn, the Staff, as part of the socialisation programme, would arrange a barbeque for patients on the lawn to the south of the building. The delightful smell of grilling meat often wafted across to the headquarters building and the staff working there sometimes wondered who were better off, they or the patients. On a warm, sunny day, the view and the smells were even more enticing and bucolic and generated fantasies of drowsing peacefully in the shade of one of the spreading trees.

Colin Haynes also recalled the early days at St. Corantyn:

"Soon after we moved in, I was coming up the Anzac Highway to work in a very severe thunderstorm. There was hail, heavy rain and strong wind. Howard Lloyd arrived at St. Corantyn at about the same time as I did. We opened the front door and there was a six inch waterfall coming down the full length of the main staircase. The house had box gutters and guttering and the hailstones were so severe that they blocked up the box gutters and the rainwater ran back in and down the ceilings and walls and down the staircase and out the back door. I can't remember what Dr. Cramond's comments were. For the next day we were moving carpets and drying the place out. And that was the very modest start of the Mental Health Services".

Haynes had a profound respect for Howard Lloyd, having been associated with him, one way or another, for twenty years. "He had a remarkable ability to get people to work for him - you know, like 24 hours a day. It didn't matter who they were. He worked 24 hours a day himself. Haynes remembered an occasion, while he was "sort of looking after Northfield Mental Hospital", when he was given a job at Mental Health Services Headquarters to help Howard take over St. Anthony's Private Hospital at Joslin. The hospital had been acquired by the Alcohol & Drug Addicts Treatment Board, which, at that time, had no administrative staff for taking over the hospital:

"I complained to Howard that the game was getting a bit hot. Lloyd said: 'Did you go home to bed last night?' I replied: 'Oh, yes. I got home to bed about half past ten and I got up again at six

and went to work.' 'Well', he said, 'you've still got plenty of time to work'. That was his guiding principle: if you had time to sleep, you had time to do more work. He'd stay at work all night".

Despite the pressures, Haynes said: "In those days you had to get things done with very little. Cramond was an expert in doing that and so was Howard. The staff we had was absolutely minimal for years. But they were good days".

Dr. Cramond very generously acknowledged the part played by Howard Lloyd and Colin Haynes:

"I had the broad ideas and the broad vision, the wide sweep of where we were going and how it might all fit together; and they were the chaps who made it happen. They both got excited about it, and, because they knew their way around the public service procedures, in ways that I certainly never even tried to, they were the ones who did all the detailed work and brought it about. So the broad brush was mine and the careful detail in public service procedures was very much theirs".

The relationship between Cramond and his staff can be seen from two perspectives. Cramond stated:

"I've really been extremely fortunate, in the professional administrators I've worked with, that I was allowed to do the broad brush work, to have the vision, to be able to sort of pick up other people's ideas that seemed to me to be practical and sensible and could be applied to the situation I was facing. That was the design. Then there were the people, the Howard Lloyds, who made it all come about and made it work. Because I really never had the time. I always felt that it was important to be the clinician, that I should keep in touch with the troops at the front end. I knew what they were talking about. They couldn't put one over me, because I was sharing the clinical work and knew as much about it as they did. And by the same token I was able to interpret then-problems to the professional administrator, because they were also my clinical problems".

Interestingly, from the other perspective, Howard Lloyd confirmed that, in the early days, he saw himself as a facilitator:

"Cramond used to have all the ideas and write all the reports. His short-coming was that he really didn't know his way round the Public Service. It's not really what you know in the Public

Service, it's more a matter of who you know and how to go about things. So I always felt that my main role was to support him and to be the facilitator of his plans".

Lloyd also believed that he was able to facilitate Cramond's plans because, on the overall scene, the Government had accepted his report for the development of the Mental Health Services and was very receptive of what he was doing. They were prepared to go along with his recommendations; "that is, until they began to fear that Cramond wanted to do everything in one year instead of five years. They didn't want him to send them broke".

I asked Bill Cramond whether, when he came to South Australia, he found the Government sympathetic to what he wanted to do. While replying in the affirmative, Cramond said that he also thought he was very lucky that he came to South Australia at the end of the Playford era. The State had passed through the time when, after the War, all the money available had to go into developing secondary industry in an economy that had been based on primary industry, on sheep and agriculture; when the priorities were energy, power, roads, transport, communications, schools and housing. This meant that, from a politician's point of view, social issues, while very important, could only be developed after these other priorities had been dealt with. That was how it had to be. Now, all these things in large measure had been done. Playford held office by only a slender margin. The Liberal and Country Party was being pressured by the Australian Labour Party. Cramond was able to cash in on this situation.

The Minister for Health, Sir Lyell McEwin, was really very unwilling to come round Parkside Mental Hospital. It was something he found difficult to do. But, after Cramond had been in post for about a year, McEwin paid him a visit. When showing the Minister round the hospital, Cramond drew his attention to a bath at the rear of the Male K wards, where mentally retarded adult men were housed. Soiled bed clothes were removed each morning and a working patient washed the greater bulk of the faeces from the linen in this bath. He rather wickedly pointed out that the heavily soiled and polluted water was tipped into a nearby creek which later found its way across the Victoria Park Race Course. This clearly had an influence on Lyell McEwin. Cramond acknowledged that the Government, made up of political pragmatists, knew something had to be done.

This sympathetic attitude of Government, admittedly at a sensitive time as an election was coming up, was illustrated by a revealing incident. It must have been around the end of 1962 or thereabouts that Heads of Department received a docket requesting that they brief the Premier on things that had been achieved or developments that were intended that he could use in his electioneering speeches. Cramond admitted that this annoyed him a little bit and he did a rather smug report on "If you give me a year or two I shall certainly be able to give you something but at the moment things are so dreadful that we are just in the planning stage, thank you very much" sort of thing. The Premier sent for him.

Cramond recalls:

"I went in fear and trembling because I realised I had been a little bit too smart maybe. He saw me in the Old Treasury Building in Victoria Square, that delightful building architecturally. He had a little fire going in his office with some mallee roots, and he sat me down in a leather armchair alongside the fire. He drew up his chair on the other side and he handled me like a rather dim-witted nephew of a rather fond uncle, though he had never met me before. He explained that he was an orchardist and that before the apples could come beautifully in the trees you had to do reticulation and you had to get the water in and you had to plant trees. He knew I would understand this being an educated chap. And, of course, I had to nod 'yes' and then he metaphorically patted me on the head and told me to run away and write a paper telling him about the reticulation that I was doing. He was absolutely right, of course. But, it was his skill in summing up how to handle me. He could have given me a fearful rocket and sent me away angry and upset and bloody-minded, but instead he chose to disarm me completely. I'd been impressed with what he had done; but I became an enthusiast for him after that".

One of Cramond's learning experiences at Woodilee Hospital was the recognition that the Victorians built their hospitals with a view that they were going to be still there in a hundred years' time. He remembered an incident when he said cheerfully to the Clerk of Works: "I want a door through here to make these two wards into one"; and the clerk replied in a pained voice: "You realise that's a week's work you're asking". The walls were so thick; they were built like castles. He learnt you really can't plan for

much more than five to ten years. The important thing was to keep the planning flexible. That was why, in the design of Strathmont², the buildings were made up of small units that could be flexible. He admitted that he did not know what would happen in the years ahead and he didn't want to leave his successors with another Parkside. So, he was able to express gratitude to Lyell McEwin and the Parliamentary Committee that allowed him to plan for two hospitals for the mentally retarded, one north and the other south, with the second one being held in reserve so that they were not putting all their eggs in one basket.

But, as far as buildings were concerned, Lloyd maintained that they could never have done what they did without the help of Joe Craig³ from the Public Buildings Department and a "very good friend" in the Lands Department. This man was on the Valuation Board, and, whenever Cramond wanted to buy a property, this chap would negotiate with the owner, who always wanted more than the Government was prepared to pay. They always got the property at a pretty reasonable price. Because he had access to people such as these, Lloyd could always explain in administrative terms what it was all about, in contradistinction to Dr. Cramond who could explain his ideas in medical terms. Lloyd also claimed that they always got results quickly because he adopted the idea, or the motto: "you never let the bastards get you down".

"Over my lifetime, it had become evident that you could get anything you liked from the Public Service Board so long as you stuck to it and never gave up. Of course, we would break all the rules in the book and tell them about it afterwards. The Government Auditor at the time always said that I was the biggest bloody pirate that the Hospitals Department ever had; but he agreed with it because, although I broke all the rules, I always got the results. We used all the facilities that we could find in the major hospitals themselves, in the way of labour, machinery and everything else; and Joe Craig helped in the buildings, and Dr. Cramond got the Minister's approval for these things. That was how the system worked".

Colin Haynes was even more positive:

"I think Dr. Cramond attracted people to work for him. He attracted people by his general personality, by his enthusiasm and his direct way of doing things. Once anybody got near his organisation he pulled them right in, got them in and they couldn't help themselves. I couldn't. He

had a wonderful way with people. From the first time you met him he was right on your level. There was no pretence about the man. He would tell you, when he gave you a job to do: 'You do this; I don't know anything about it'. You realised full well that he knew all about it and if you hadn't fixed it up very quickly you would hear all about it. He gave you the responsibility to do things. I always recollect one incident that epitomised the satisfaction of working for him. He came back one day to the then headquarters in St. Corantyn, and called Howard and me into his room and said that he had purchased a motel, out at St. Peters way somewhere; the place we now know as Palm Lodge. He said: 'You can fix up the paper work with the Lands Department. I want it set up as a hostel, a half-way house, for people who are ready to leave hospital but are not yet ready to go out into the community'. We knew quite well that that was the only instruction we were going to get. He had purchased that property without prior approval and it was our job to go to the Public Buildings or Lands Department or the Minister of Works and get the purchase effected and paid for and to find the money to get it started. We had the thing going in a month because we knew full well that one day he was going casually to ask Howard and me: 'Well! How's it going?' When he said he had bought the motel, he omitted to tell us that he had bought the house next door, also. The motel had no kitchen facilities and we had to set up the cottage next door as a kitchen. We sort of floated round the hospitals seeing what was there - one refrigerator from here, some stoves and tables and chairs from there. We had it open in a month and it has been going ever since. That was typical of the man. Working with Dr. Cramond was probably the highlight of my career because you could achieve so much with him".

About three months after Lloyd was appointed, Cramond told him that he had suspected that the reason he had been recommended by the Hospitals Department for appointment as Secretary of the Mental Health Services was either that they were trying to palm off on him one of the no-hopers they did not know what to do with or else so that he could spy for the Department. Lloyd said: "I did not suspect this. I thought it was a new position. About the last six positions I had occupied in the Public Service had been new positions. In all cases, it was very much up to me to make what I could of the position and develop it from there". That he succeeded in doing that in the Mental Health Services is illustrated by Bill Cramond's most complimentary remarks about him.

Lloyd recalled:

"On a few occasions, Dr. Cramond would come back from seeing the Public Service Board or the Minister and stamp into his big room at St. Corantyn and sing out: 'Howard, come in here. I want to talk to you about something'. And I'd go in and he'd stand at the side of his desk and fling the books and papers he had on to the floor and say: 'Do you know what the buggers have done to me today?' and then he'd tell me what they had done to him. He was a man who didn't suffer fools gladly and he certainly wasn't good at bearing frustrations. But he was a man of very deep convictions, a very determined man. He was a very good man to stick to his principles. He never departed from the principles he wanted to follow. He was a 'workaholic' when he was really working. But I got on very, very well with him; we never had a cross word or anything in the whole of the six years I was there".

In Howard Lloyd's opinion, Dr. Cramond got on pretty well with the Minister, Sir Lyell McEwin. He was less sure about Dr. Rollison, head of the Hospitals Department, whose background was in the general hospital field. Nevertheless, in the early days, they used to put a lot of stuff up to the Hospitals Department, through the Secretary, Jack Moule, and Dr. Rollison, and he could not remember any occasion when either of them thwarted anything Cramond wanted to do. They used just to send it on to the appropriate Minister or Head of Department. "Of course", said Lloyd, "if they didn't send it on there were always a lot of complaints from the Mental Health Services asking why the hell they were holding things up. I don't think anyone really thwarted Dr. Cramond, no one ever really said 'No'. It was the delays that used to frustrate him".

Both Lloyd and Haynes agreed that Bill Cramond had a pretty bad temper which he used to display now and again; not very often but when he did it was very spectacular. Haynes recalled one story, which he admitted might have become a bit exaggerated over the passage of the years. This was the time when Cramond came back to Headquarters after being frustrated by the Public Service Board or somebody, picked up the phone on his desk and threw it on the floor, tearing it from the wall.

He told another story:

"Dr. Cramond wasn't at all worried by his surroundings. When we got started, we had scrounged him a second-hand desk and an old chair. But then Howard decided to set him up with a very nice desk and a very nice chair to give him a bit of dignity in his office. So Howard got on to the Public Buildings Department, and they went overboard as they usually do. They came back with a huge desk and a very, very fancy chair. Cramond wasn't too impressed with all this expenditure on his personal comfort. We put this chair with its back fairly close to the wall so he could see out the window, with the desk in front of it. One day we heard this crash from the room and someone making some violent observations about certain things. We went in and found Dr. Cramond stuck in the chair, with his head to the wall and his feet in the air. He had leant back in the chair and it had tipped over backwards and he couldn't get out. We had him pinned up against the wall. I think we had to change the chair after that".

One of the things that amazed Haynes, and he thought amazed everybody, was the rapidity with which Cramond got things done. If he wanted to buy a building, for example, it would be done ten times as fast as he had ever seen anything done before. He believed Cramond's success depended on his personal relationships with people. He would always make a personal approach. "But" Haynes said, "added to that, was the very personality and the drive of the man. I'd never struck anyone like him before in my lifetime".

Haynes and Lloyd both agreed that Cramond never pretended to have any administrative skill. When he had got something ready or purchased something, he would throw it to Lloyd and say something like: "That would make a nice child guidance clinic". That would be his only instruction; and from there on they would set it up as a child guidance clinic. Haynes said that it gave him a lot of satisfaction just to realise that the man had confidence in him and let him do it. "It was great fun doing the job when he left you alone and didn't ride you all the time. I think it got done a lot more quickly because of that". (Harry Kay made the same comment that the big change from working for Hugh Birch, who tended to keep things to himself, was that Cramond used to say "You do it".)

Howard Lloyd acknowledged that he owed a debt to Bill Cramond. "He was the sort of guy that suited me. During the time with him, there was always something different, something new going on. Actually, he was the fellow who induced me to take up study for a qualification in health service administration. I was nearly 45 years of age and I enrolled with the University of New South Wales to undertake this course mainly as a result of his urging". He completed the course successfully, much to his credit, and joined the relatively small band of members of the Institute of Hospital Administrators, now the Australian College of Health Service Administrators.

Colin Haynes complimented Cramond on the fact that he involved everybody in the things that were going on. He would put things pretty simply, pretty plainly. For example, he stated categorically that, so far as the disposition of patients went, he had one ambition in view, and that was to get the mentally retarded and the alcohol and drug addicts out of the mental hospitals, and to separate the mentally ill from the mentally retarded and the geriatric patients from the others. He wanted to make the mental hospitals places for the treatment of psychiatric patients and not a sort of dumping ground for every destitute person or social problem that nobody else in the State could handle.

During his time with Dr. Cramond, Haynes witnessed some remarkable changes. When he first saw Parkside Mental Hospital the walls were coming down. Most of the wards at Parkside were surrounded by stone walls and ha-has⁴ or twelve feet high half-inch cyclone mesh or galvanised iron fences. It was a most depressing place: "You know - fifty people in a ward with only two toilets". Cramond unlocked the wards, pulled down the fences and walls, filled in the ha-ha pits and planted lawns. This caused some consternation Haynes claimed. "He just transformed the place. People said that we would have lunatics running all over Adelaide. I think he eventually produced some figures that showed that the escape activity actually dropped quite a bit after the doors were unlocked". This confirmed the observations Bill Salter made at Northfield Mental Hospital and already referred to⁵.

Haynes said: "I never regretted going to Mental Health. I've got a great affection for the Mental Health Services. I found it wonderful working at Northfield Mental Hospital".

Howard Lloyd left the Mental Health Services in June, 1969, to become Assistant Director General of Hospital Services. Colin Haynes ended his Public Service career as Senior Administrative Officer to the Minister of Health.

CHAPTER 7

STRATHMONT

I have already, in the discussion of the "Cramond Report", referred to the recommendation Cramond made that planning should begin for a new hospital of some 800 beds for the intellectually subnormal. The concept was approved. However, the Minister flatly rejected his other suggestion that he and a senior architect of the Public Buildings Department be sent overseas to investigate the modern design of such a hospital and the services to be provided. Later, a more limited trip interstate and to New Zealand was agreed to.

In a "Memorandum on the proposed Hospitals and Training Centres for the Intellectually Retarded", submitted to the Minister of Health, on 16 August, 1962, Cramond stated:

"These plans are the result of personal study of the conditions pertaining elsewhere and were helped in their clarification by the tour undertaken recently to Victoria, New South Wales and New Zealand by the Chief Architect of the Public Buildings Department, one of his senior colleagues and myself." (This "senior colleague" was Joe Craig to whom reference will be made later.)

Early in the report, he urged that a decision be made whether one hospital and training center of approximately 860 beds should be built, or whether two smaller centers of 430 to 480 beds be erected. World Health Organization opinion was quoted that strongly supported the view that, in the future, no hospital or institutional building ideally should exceed 400 beds. All buildings should be of single storey construction with adequate play and garden areas around them. Wards should not exceed 24 beds. A diagram was attached to the report which illustrated the possible layout of the centre. It showed the children's wards grouped around a village green, with training buildings, occupational therapy and school nearby; adult wards were similarly to be built around an oval, in a separate part of the grounds, and

grouped with the sheltered workshop area. The children and adult wards were separated by a village centre comprised of a recreation hall, a gymnasium, the administration offices and the various service areas.

Two considerations were taken into account in the planning: an economic size for the hospital and training centre, and the anticipated population of the State of South Australia in 1975. The Strathmont Centre was to be built on land adjacent to Northfield Mental Hospital (later to be known as Hillcrest Hospital). The Elanora Centre was to come later, on land reserved at O'Halloran Hill. This centre, south of the River Torrens, was never constructed. Policies changed as a result of experience. Hostels, both government and private, became available for the care of the intellectually retarded; and sheltered workshops were set up in the community by the Mentally Retarded Children's Society of South Australia. This was an example of the fact that many advances in the Mental Health Services were encouraged, assisted and even made possible by the parallel efforts of voluntary organizations. Individuals helped, too. Such a one was Joe Craig.

Joe Craig first met Bill Cramond when he joined the party, already referred to, that toured Victoria, New South Wales and New Zealand. Craig believed that, even prior to this and soon after Cramond's arrival, he had been asked to set up an architectural section in the Mental Health Section of the Public Buildings Department because his superiors had become aware that he would be active in trying to get things done.

There was no doubt that Joe Craig both admired Bill Cramond and enjoyed working with him:

"Bill was probably one of the easiest people I had ever had to deal with. I always thought of him as a client; and he was the most easy, informed, understanding, practical client I had met. He seemed to understand, intuitively, all the problems concerned in building, as far as the architect was concerned. He knew that, if you were to achieve something, you had to pre-plan; you had to set targets, set dates, in order to achieve it. That meant that there was time for thought in the concept stage; there was time then for development of that concept; there was a time when you must make decisions and to design; you had to complete those designs, get them all ready for

calling tenders; and then you had to engage a contractor, build and complete the work by a due date. Bill never had to be reminded of these kinds of facts; he understood them."

Although, as an architect, Craig had to be on the side of making decisions, completing documents and finalizing a contract, underneath he always took a similar attitude to Bill Cramond: as long as it was not a final commitment he was prepared to change, to vary the contract if it were really going to improve the design. He had a flexible attitude, up to a point. There were certain times when a decision had to be made: "That's it - no more discussion". At other times: "Right - we've left our options open". He said: "With Bill it was very easy. We felt, both of us, that, at the end of an exercise of designing a building or a facility, we had really achieved as much as we could on that project".

"Bill was an amazing person. I'd never met anyone quite like him. He seemed to have the ability to achieve in whatever area he wanted to achieve. Whatever his interests, he seemed to have the ability to go straight to the top in double quick time. He was just a very good - manipulator is not a nice word - manager, if you like, of people, and he did it in such a way that they didn't know it was going on. He could get them all thinking, get them to see clearly what the important factors were and the sense it all made. That was the way Bill seemed to arrange that things would happen. He was never in the front line when things happened; he was always back there somewhere. He never wanted to be up front, leading anyone or anything. And, yet, that was, in fact, what he was doing. In the most pleasant way, he was able to achieve the situation that everyone wanted to do the one thing. A year or so later, when they looked back, they found that it was, in fact, the thing he wanted done. Of course, he fully involved staff. They were part of the whole thing. I've never known anyone who was part of a team with Bill who didn't enjoy it. And, at the end, you knew you had achieved what he had set out to achieve."

It was perhaps fortunate that the Government was slow to proceed with the construction of Strathmont, from lack of funds, because valuable time was provided to review and keep modifying the design. The biggest and final modification was as the result of a visit Joe Craig paid to Scandinavia to attend a conference that was being held in Copenhagen. This was in 1966. At that time, they had more or less

completed the design drawings. The residential units were laid out around a village green for the younger ones and a playing oval for the adults. They were all arranged as a village, Cramond's idea of an ideal place for the intellectually retarded to live. A villa unit had been developed that provided accommodation for twenty-four persons to live in as a home unit. Units were arranged to form a block of forty-eight beds.

When he went to Copenhagen, Craig took all the plans and drawings of the Strathmont scheme, with slides of the drawings and the models they had made. He admitted that he was really keyed up, convinced that he was going to present the most advanced and the best project ever. He remembered:

"At the discussion that followed after I had delivered my paper, it became clear that the idea had developed in Scandinavia, and probably over the twenty years before that, that there was no hope for any retarded person to develop as a human being in a group of more than twelve people. It took me a week to discover the significance of this. After all, we had got to the stage of having committed ourselves to the design I had brought with me. In fact, we were actually in the process of preparing contract documents back in Adelaide. And, here was I getting the message that what we'd designed really wasn't going to be any good. It took me about a week to accept the fact that what we had done was not good enough. So I wrote back to Adelaide, told them what I'd heard, what I thought and what I now believed: that we had quickly to set about redesigning the buildings to produce a villa with four units each for no more than twelve people. Another point that they were making was that the design of the villa should be such as to make it impossible for any administration subsequently to put in more than the maximum number of people. In other words, you designed for a maximum occupation of any living unit."

By now Cramond had become Professor of Mental Health at the University of Adelaide and Dr. Brian Shea was Director of Mental Health. The villas were redesigned with his approval. The final design that emerged was, in most villas, for four units each of eight beds, or thirty-two per villa¹. In this process of redesigning, Craig claimed, an amount of half a million dollars was knocked off the cost, though a quarter of a million was absorbed by the engineers in services that should have been included in the original estimates but were overlooked. Joe emphasized this point because, later, there was criticism that Strathmont was a "most luxurious complex". He argued staunchly:

"What made it look luxurious lay in the design factor: we were in fact designing for economy. One of the ways we achieved this was to have, say, 90% of very plain, very simple, very common materials, with a 10%, or maybe down even to a 1%, expensive item, a little jewel, if you like, to sit in front of this inexpensive background. The kinds of thing I am talking about were the two fountains. We put in two fountains, one in the central court of the administration building, and one in the larger court situated outside the complex that consisted of the main hall, the swimming pool and the administration building. I think that together those would have cost something like \$12,000 out of a \$6.5 million budget; but, nevertheless, they gave the impression of being luxurious. We paid an artist something like \$1,000 to design pull handles for the chapel door. They were very nice, beautiful pull handles: again, they were considered to be extravagant. The dining room had an internal court which was glazed all round. We had a piece of sculpture positioned in the internal court which could be viewed by the diners. It was done by a local artist. Now, again, that cost us only a few hundred dollars, because we weren't aiming to spend big money on these things and most of the artists were working because they wanted to be part of the project. We finished up with a piece of sculpture in a beautifully planted inner court that looked very expensive but wasn't expensive. It was just good design. Unfortunately, people don't appreciate that good design does not equate with expensive design. Good design to me is, in fact, economic design.

"Another little design feature at Strathmont was that each villa had an identifying panel depicting an Australian bird or animal, and the villa took its name from the Aboriginal name of the bird or animal. One of the architects, Lee Emmett, actually designed the panels. He worked with the brick company which cast the parts of each design into bricks and glazed. The parts were put together to form each panel with its distinctive design. Now, again, that cost nothing; it was an example of architects working on the job. The brick company did it because they, too, were enthused about this project and wanted to be party to making it as good as it could be. So, it didn't cost us anything to make the panels; but it turned out looking so good that it was condemned."

The idea of identifying each villa with the picture of an Australian bird or animal, and its Aboriginal name, was the brain-child of Dr. Norma Kent, who succeeded Dr. John Covernton as Assistant Director, Intellectually Retarded Services. Dr Kent was born in New Zealand and recalled learning Mauri songs and Mauri history at school. When she came to Australia, she was impressed with how little Australian children knew about the history and the language of our own Aboriginal people; and she came to the conclusion that New Zealanders were more comfortable with the language and symbols of their indigenous people than we were. So, she decided to introduce the notion that the intellectually retarded children and adults at Strathmont should recognise the villa which was their home by means of a native creature and its corresponding native word.

Dr. Kent also conceived the idea of having an identifying logo which would appear on all literature and notepaper. It was, literally, put into concrete form by Lee Emmett², who designed a cluster of three very tall cement "trees" which represented "growth", and stood at the entrance to the Centre. They became an imposing landmark.

In design, Joe said that he took the attitude that whatever he designed should be the kind of place he would like to live in. This was the sort of test applied to Strathmont: would the doctors, the nurses, the architects want to live in it? So he was pleased to have his view confirmed by the second message he got from Scandinavia: that you don't design for second class people or for first class people or for anything else. In Sweden, a lady doctor, at one of the hospitals he visited, made the point that the approach should be to design for normal people. The approach was the same in Denmark. It was important to forget that they were subnormal or retarded or whatever; they were people. That was the message that kept coming through to him from the various places he visited, those he regarded as the more enlightened ones. (It was probably Joe's first brush with the term, "normalization".) This learning experience was important for Craig, because, before he left Adelaide, a great point had been made to him by the nursing staff that you can't have this or that, or do this or that, with the severely retarded. "You can't afford to have light fittings that can be broken; you can't have switches that can be reached; you can't afford to have windows that they can get out of or break." In other words, he had felt that he was being asked to design some sort of security

block, and he had been instinctively against this. So, during the design of Strathmont, he had believed that the biggest fight Bill Cramond would have would be to change the attitudes of some of the staff at that time.

A third message that came through from the Scandinavians was that institutions were a present necessity; they were not the answer. According to Craig, this was also Cramond's view. Even when everyone was pleased with the result at Strathmont Centre, he recalled that Cramond used to say: "Really, we shouldn't be building these institutions at all, but at this point of time we need it". His belief that institutions were on the way out was confirmed, of course, by the fact that, though the figures then showed the need for a second institution - the Elanora scheme to service the southern districts of South Australia - and though, in fact, both schemes had been presented to and approved by the Public Works Standing Committee, the second Centre was never built.

Because the intellectually retarded patients, some six hundred of them, were already in Parkside and Northfield Mental Hospitals (later Glenside and Hillcrest Hospitals) Cramond put the building of Strathmont Hospital and Training Centre as his first priority. He knew that he had to separate the retarded from the psychiatric patients before he could proceed with what Joe Craig believed was his top priority, the upgrading of the outdated accommodation and facilities at Glenside Hospital.

Strathmont Centre was built without a conventional kitchen. Cramond first conceived the idea of using frozen food. It was while they were flying to New Zealand in an "Electra" aircraft and enjoying a splendid meal in First Class. He asked Craig how it was done and they went on to discuss the idea as it could apply to the proposed hospital. The first time around, the idea was put in the too hard basket. Then, Dr. John Covernton, the Assistant Director, Intellectually Retarded Services, who had heard of investigations being made in the eastern States into a frozen food service or catering system, possibly by the Army, suggested that the method could be looked into for Stathmont and the Mental Health Services. For his part, Craig had to admit that he had never had occasion to think about it before. However, he saw the idea as a logical development in the improvement of catering services: it would be a great achievement to divorce the preparation of the meal from the actual serving of that meal. The thing that seemed to drag down conventional catering was that, though the method worked all right at home, it was difficult to repeat the

exercise for a thousand people and to stick to meal times. Staff had to start very early in the morning to prepare breakfast; and, throughout the day, they had to keep ahead of the meal-time, which meant having the actual meal ready some hours before anybody was ready to eat it. He recalled the experience at Glenside Hospital:

"We had some pretty rough roads and some pretty rough equipment for moving food around. The meal had probably been prepared some hours before it finally shuddered along the path to a dining room, possibly to be put into another heated chamber to be kept, for the final half hour or so, before being presented at last for someone to eat. By that time, the food had been pretty well vibrated out of all recognition; it had probably lost its temperature; it had certainly lost its taste, and it was of no interest to anyone except the absolutely ravenously hungry. The thing that attracted me to frozen food was the fact that the preparation of a meal could be arranged as a sort of commercial operation quite separate from the actual eating of the food. What had been cooked in the first instance could be delivered and served up on the table with no deterioration."

When he went to Scandinavia, Craig looked at frozen food services. In Sweden, one hospital had developed a chilled food service, not quite a frozen food service. In Britain, he made enquiries from "Birdseye" and "The King's Fund" about experiments being undertaken in Leeds and other hospital centres. The information he received supported the view that conventional services were breaking down all over the world. Though more sophisticated equipment was being put into bigger and better designed kitchens, the difficulty remained of finding sufficient, well-qualified staff to provide the service. There was an impediment always to bridging the gap between preparing a meal and having it served up to be eaten. The time factor was beating everyone. Conventional kitchens also had something like a 14% built-in waste factor; that disappeared to a zero factor with a frozen food service.

On his return to South Australia, experiments were carried out and various techniques were explored before a system was designed for Strathmont. The technique chosen was snap-freezing with liquid nitrogen. This method achieved a temperature of -20 C. in something like two and a half minutes. A wide range of options was possible. All that was required was that the technique be known and the procedures followed. A tunnel for the purpose of trying out this method was installed in the kitchen at Glenside Hospital. There

were critics, of course. To them, Craig put it this way: "If you put a cordon bleu meal into the freezing tunnel, you get a cordon bleu meal out; if you put a rubbish meal in, you get a rubbish meal out".

As far as Strathmont Centre was concerned, the great advantage of the system was that meals could be prepared, cooked and deep-frozen at Glenside Hospital, delivered to deep-freeze storage at Strathmont, conveyed to the refrigerators in each villa for reconstitution, and finally reheated in a microwave oven when it was actually needed. Mealtimes in each unit could be flexible and related more to the activities of the group rather than to the requirements of the kitchen staff. The food was always hot and appetising. There was more control over the size of the portion each child or adult received. Over-feeding was made harder to achieve. The experiment at Strathmont was so successful that a frozen food service was approved for the Health Services and a Frozen Food Factory constructed.

I came in at the end of the investigations and planning surrounding the introduction of snap-frozen food to the Mental Health Services. Cramond had started it; Shea had supported it and I watched it develop. There is a wry twist to this. When, as a member of the Association, and later the College of Psychiatrist, I had visited mental hospitals in the various States, I had always been insufferably bored when being shown the kitchens and such like. And, here I was in 1968, as the newly appointed Director of Mental Health Services, being required to be involved in and to show an intelligent understanding of the freezing of plated meals in a tunnel filled with liquid nitrogen. For one who had spent the greater part of his psychiatric life in clinical work, I had to make quite a massive adaptation. I enjoyed the challenge. I also became a great protagonist for the concept of snap-frozen meals and the great flexibility it provided the nursing staff. Meals could be taken at a time to suit the particular activity and not be dictated to by the rosters of the kitchen staff.

Bill Cramond believed that, ideally, the design of a hospital or other health facility should provide for maximum flexibility. Joe Craig therefore looked at the possibility of a demountable construction for Strathmont Centre; at something that could be bolted together at one time and later unbolted to modify or drastically change the design. Unfortunately, the cost of such demountable construction was something like three times that of more orthodox construction. Cramond was disappointed, because he would have liked

to have had the satisfaction of knowing that he wasn't committing future generations, or even the next year, to ideas which he had thought right this year. He knew, from his own experience, that ideas that had been thought to be right today may be proven to be wrong tomorrow. He had also learnt that the structure of a building could be one of the greatest inhibiting factors against change. Buildings tended to freeze systems. They had a lot to do in forming opinions and in maintaining opinions, and making it very hard for people to break out and change.

Craig agreed that the design of a building could have a lot to do with forming attitudes and in maintaining attitudes. As an example, he quoted attitudes that were commonly held in relation to the use of carpets in hospitals. In his view, in designing a hospital, he should make the accommodation and the furnishings as near as possible to what was enjoyed at home. Carpet was an important element in making a place cosy and inviting. But the medical profession and the nursing staff were very resistant to the idea. The assumed problems of keeping the floor properly clean constituted the main objections. What would happen if pans of faeces or other unpleasant things were dropped on the floor? Or, you can't put carpet in the dining room; people will spill their food on it! To this he would retort: "Well, Try that on the 'Hilton' some time and see how they react to the idea of putting vinyl flooring in the dining rooms." When anything up to a hundred or more people are eating in a dining room with a hard floor and a hard wall and a hard ceiling, even a dropped spoon will cause a major upset; whereas a plate can be dropped on carpet on the floor and nobody will even notice. As he pointed out, the solution lay in a different approach to cleaning procedures, but the old ideas and prejudices were hard to shift.

The concept of homeliness and flexibility developed in the basic unit of eight beds was carried over into the design of subsequent Mental Health Services buildings. Just as in Strathmont where each eight beds were associated with a play or work area, so each basic eight bed unit in a hospital ward had incorporated within it a multi-purpose room. It could serve as a lounge or tea room; it could serve as a group therapy room, a place where students could meet, or a quiet room. The room was designed to have maximum use and not be dead space that would lie idle for much of the time.

The idea of a vibrant, living village centre in the design of Strathmont also became transferred to the concept of a living, dynamic centre in the design of the individual ward in the hospital. One afternoon while driving past the Enfield Hotel on Hampstead Road, on our way back from Strathmont Centre, Joe Craig suddenly said: "That's how we should design a hospital ward - like a hotel!" He went on to elaborate. "In the large, modern hotel", he said, "there is an extensive entrance foyer, with easy access from the street, where guests and those who come in from outside can mingle freely. Toilet facilities are provided for visitors and there is the opportunity to have a cup of tea or coffee with friends. From this open entrance area, people move to more specialized areas. Lifts and hallways lead to the accommodation wing, to bedrooms, bathrooms and toilets, even to suites with private lounges. Hairdressing and beauty salons and specialty shops are located in a selected area. In another place, the offices and administrative services are to be found. Reception is often adjacent to the entrance foyer."

The first building to be designed in accordance with these philosophical principles was the Adolescent Unit, situated in the grounds of Enfield Hospital, and named "Willis House". This was opened on 23rd August, 1974. The next, opened on 3rd October, 1975, was "Litchfield House" at Hillcrest Hospital. Inspection of the plans for both these buildings³ will show that they were based loosely on the eight-bed bedroom set-up, with associated "living" room. In the adolescent unit, the unit bed numbers were increased by the provision of four-bed dormitories. Because Litchfield House was an acute admission ward, the number of beds in each unit was related to function: four beds in the acute area, eight beds in the two sub-acute areas, and fourteen in the convalescent area. However, in all but the acute area, a multi-purpose room could serve as a group therapy room or lounge.

With appropriate modifications for the needs of different classes of patients, such as psychogeriatric patients, this basic unit could be expanded to a villa of 32 beds, as at Strathmont, to 40 beds at Litchfield House; to a double unit of 64 beds as at Glenside Hospital; and even to larger wards. Flexibility could be maintained and the small group philosophy preserved even in a very large ward complex such as the 128 bed psychogeriatric development at Glenside and Hillcrest Hospitals.⁴

Apart from Strathmont, Craig could not recall that Cramond was involved in the detailed design of other buildings, although they could have been part of the overall plan he had arrived at very early on. Cramond had developed what he called his three-year plan and his ten-year plan. His three-year plan included the Strathmont Centre type development and a few other things; the ten-year plan was for the total conversion of the whole service, including the upgrading of Glenside Hospital, Hillcrest Hospital, Enfield, the lot. The redevelopment of Glenside Hospital was to be in four stages. Craig was sure that Cramond had in mind the creation of a centre, as had been done at Strathmont, around which all the other parts would be clustered - a village, even a little township, in which people would live and relate to.

On a smaller scale, Craig helped with the refurbishment of St. Corantyn, the grand mansion that had been purchased as a Day Hospital and in which Cramond, in his early days in South Australia, was to have his office. He recalled that, when they were upgrading the place and preparing for him to move into his office, which was a fairly big room, consideration was given to providing him with a desk. Officers of the Public Buildings Department were conditioned to give the head of an organization the biggest desk. There was an acknowledged scale of desk sizes and the head of a department got the biggest. He remembered Cramond, not jokingly but very seriously, trying to talk them out of giving him this very big desk. Craig was sure that some attention was paid to the request, but, notwithstanding, when he received the desk it was still too large. "Bill hated the symbolism of the big desk and disliked sitting behind it. If you ever came into the room, he would move smartly away from the desk. It was just another part of Bill that I remember."

I enjoyed working with Joe Craig. I found him a stimulating person to talk to. He was a man of original ideas, which he could express clearly and often profoundly, not only in his chosen field of architectural design, but also in more diverse subjects such as the freedom of the individual, the importance of quality of life, the way technological advances could produce a revolution in the organization of society. He was a humanist and a compassionate man. We had agreed to meet again, following my initial interview in April, 1982, but I delayed too long. He died suddenly while on a boating holiday and I never did share that bottle of claret and record more of his views, beliefs and opinions.

Strathmont Centre, with its symbolic, cement tree-arms reaching to the sky, stands as a memorial to Joe Craig and to the many who collaborated with him.

CHAPTER 8

DIRECTOR OF MENTAL HEALTH SERVICES

(i)

In 1967, I attended a meeting of the Scientific Programme Committee of the Royal Australian and New Zealand College of Psychiatrists. Dr. Lothar Hoff, Superintendent of Glenside Hospital, and Dr. Rayner Smith, a psychiatrist in private practice, were present. The vacancy created by the promotion of Dr. Brian Shea from Director of Mental Health Services to Director General of Medical Services entered our discussion. Dr. Hoff announced that he understood that the South Australian Public Service Board would not advertise the post outside Australia. He also said that neither he nor Dr. Bill Salter, Superintendent of Hillcrest Hospital, intended to apply as they both preferred to stay closer to patients and clinical psychiatry. Then, to my complete surprise, they both said; "Why don't you apply?"

My immediate response was to protest that I had not been in the Public Service since 1946 and lacked administrative experience. They pointed out that I had really had considerable administrative experience, albeit of a somewhat different type, in the founding and development of the South Australian Association for Mental Health as its Executive Chairman from 1956 to 1966 and now its President, and as the immediate Past President of the Australian and New Zealand College of Psychiatrists. These arguments were not entirely convincing, but they confirmed my attitude of mind.

For some months, I had become aware of fatigue and a loss of my usual enthusiasm. I did not face the day with any joy. My chronic, neurotic patients depressed me. There were two possibilities, not clearly mutually exclusive. The first was that I was becoming depressed; an example of so-called "burn-out". The second, which I found more attractive possibly because it was more palatable, was that I just needed a

change. Reflection demonstrated that I had made a change in my life style roughly every ten years. I had graduated in 1939, gone to England in 1949, started the Mental Health Association in 1956 and worked for the establishment of the Chair in Mental Health in 1960, and been actively involved in the Australasian Association of Psychiatrist and its metamorphosis into the Australian and New Zealand College of Psychiatrists, becoming its second President in 1966. Now, all that activity was passing. Perhaps, I did need another challenge. I had little to lose. If my application failed, I still had a very good private psychiatric practice to fall back on.

I applied for the position of Director of Mental Health Services, somewhat to the surprise of Brian Shea and the astonishment of Professor Bill Cramond. Brian Shea must have seen some merit in my application, for it was successful. I well remember my first interview with Mr. Max Dennis, the Chairman of the Public Service Board, when he asked me why I was applying for the job. I explained that I had become interested in the broader issues of community psychiatry, the deficiencies in the provision of services and the need for greater opportunities for training, in my work for the South Australian Association for Mental Health and the Australian and New Zealand College of Psychiatrists. I said honestly that I was changing my hobby for my job. This explanation seemed to please him.

Dr. Brian Shea was Deputy Superintendent to Hugh Birch at Parkside Mental Hospital, at the time of his retirement, and to Bill Cramond when the latter took over as Superintendent of Mental Institutions and Director of Mental Health in 1961. Like Harry Kay, he was a link between the two.

He later succeeded Bill Cramond as Director of Mental Health, and had the title changed to Director of Mental Health Services, better to reflect the widening scope of the activities of the Department. He had also recommended without success that he be given direct access to the Minister of Health. He did not proceed with this when he became Director General. I found this a little amusing, but never any impediment.

(ii)

Brian Joseph Shea was born in New South Wales. He did his early schooling in that State and came to South Australia at the age of 12 years. He was a bright student and matriculated for entrance to the medical course at the University of Adelaide at the age of fifteen. At the University, he was the second youngest person in his Year. He had just turned twenty-two when he graduated. In those days, it was not obligatory to have twelve months experience as a Resident Medical Officer before becoming eligible for registration as a legally qualified medical practitioner. He registered in December 1950, did a locum in the country and returned to Adelaide. There he was advised that all the Resident Medical Officer (RMO) positions at the Royal Adelaide Hospital were filled and that the best he could do was to take an associate position, to become, as it were, an assistant to an RMO. Two or three of his colleagues from his year, who were similarly offered associate positions, declined and went straight into country practice. Shea, however, felt he needed a chance to catch up and learn a bit about medicine, something, he decided, he had been avoiding. He did also admit, interestingly enough in view of his subsequent achievements, that he was not altogether happy about being an associate. It seemed a bit like being a hanger-on to the full-time RMO. So, when he was approached to see if he would accept a temporary RMO position, which had been advertised at Parkside Mental Hospital, he accepted.

That was how Brian Shea was introduced to psychiatry. John Cawte¹, who had graduated a year earlier, was at Parkside Mental Hospital. He worked hard to sell psychiatry. As a result, Shea enjoyed the two months he spent at the Hospital. None-the-less, he still wanted to finish off his training at the Royal Adelaide Hospital and elected to return and complete his twelve months internship. Fortunately, he became a full-time RMO within a short time and did his full stint in surgery and medicine. But, the stimulus he had been given by John Cawte in psychiatry had stuck in his mind and he returned to Parkside Mental Hospital as a full-time resident medical officer in 1952.

John Cawte was still there. His stimulating influence continued. When he was transferred to Northfield Mental Hospital while Bill Salter was overseas, and then to Enfield Receiving House, Shea was able to join him for short periods. As in my own case, he enjoyed the more acute work and the absence of the more chronic patients at Enfield. However, in 1954. Dr. Birch insisted that he return to Parkside Mental Hospital.. Though admitting that they were short of staff at Enfield, Birch argued that there was an even greater shortage at Parkside. Like me before him, the return to the mental hospital unsettled him and, when he saw an advertisement in the paper seeking a Medical Officer, Grade 1, in the Mental Health Services in Western Australia, he applied, and was successful. Shea spent two years in Western Australia , from 1954 to 1956, working at Claremont Mental Hospital and Heathcote Hospital. As a challenge, he took the Psychology I course at the University of Western Australia obtaining a distinction in the examination.

In 1956, he came back to Adelaide, purely on a social visit. As a matter of courtesy, he called on Dr. Birch, who informed him that his present Deputy Superintendent was leaving and invited him to apply for the job. Shea wrote out an application there and then, and, within a couple of weeks of his returning to Western Australia, he was informed that he had been appointed Deputy Superintendent at Parkside Mental Hospital.

He now had the opportunity to review his position. He decided to start the Diploma of Psychological Medicine at the University of Melbourne in company with a number of other budding psychiatrists from Adelaide. At that time, the University required candidates for the Diploma to have three months residency in Melbourne; fortunately, this could be done in two periods of six weeks. He spent the first six weeks at Royal Park Receiving Hospital in company with his friend and mentor, John Cawte; the second six weeks, while basically attached to the Department of Child Psychiatry at the Royal Children's Hospital with Dr. Winston Rickards², he had the opportunity to attend neurology rounds at the Royal Melbourne Hospital with Dr. Graeme Robertson³. He was awarded the DPM in 1961.

Dr. W.A. Cramond arrived from Scotland at about this time. Both Shea and John Cawte were very impressed with Bill Cramond. None-the-less, they both felt that they should be doing something for themselves, rather than just being lieutenants to Bill Cramond. Cawte looked to the University of New

South Wales. Shea was attracted by an advertisement for Superintendent at Callan Park Mental Hospital, also in New South Wales. There had been a well publicised Royal Commission into the running of Callan Park, and though Shea found the job prospect exciting, he confessed that he probably would not have applied had he not been encouraged both by John Cawte and Dr. David Maddison, the Professor of Psychiatry at the University of Sydney, whom he had got to know through conferences and meetings of the Australasian Association of Psychiatrists. He went to Sydney. Maddison was on the interviewing committee. He knew before he left that night for Adelaide that he would be nominated for the position. It was rather nice not to have to wait for the official notification.

Shea started at Callan Park Mental Hospital in 1962. He remained there as Superintendent, thoroughly enjoying himself, as he put it, for about 18 months. Then it was that Dr. Bill Barclay, the Deputy Director of the Division of Establishments, went overseas on a Harkness Fellowship. The Division of Establishments comprised all the State Hospitals, that is, all the mental hospitals and the geriatric hospitals. The position of Deputy-Director of the Division of Establishments was combined with that of Director of State Psychiatric Services. When Barclay went overseas, Shea was asked to take over and act. So, he became Acting Deputy-Director of the Division of Establishments and Acting Director of State Psychiatric Services in New South Wales.

I was still in private practice at that time, but heavily involved with the South Australian Association for Mental Health. Shea had been inveigled, as he put it, into succeeding Professor David Maddison as President of the New South Wales Association for Mental Health. I had, therefore, occasion to visit him on a number of occasions. I was always most impressed how this young man controlled the largest psychiatric service in Australia. I can recall sitting in his office and overhearing telephone conversations with people in other departments and hospitals and admiring the calm, assured, expert, skilled way in which he dealt with any situation.

Later, I told him how impressed I had been at the way he had jumped to the top of the psychiatric services in the biggest State in the Commonwealth after only 15 to 18 months in New South Wales and asked him to comment. Shea replied that he thought it was basically because he was regarded as a fairly

bright young broom that had been brought in and cleaned up Callan Park. Actually, he had had very little trouble. He put this down, in part, to things that Bill Cramond had inculcated in him and which he imitated: namely, to make yourself readily available, do night rounds, carefully note what was going on. During one of his rounds, he found that "some rather unhappy brutality" was taking place. With his, as he put it, "curious medico-legal mind", he then ferreted and ferreted and interviewed and interviewed until such time as he had written some twelve pages of report. This finally impressed the Public Service Board that here was someone prepared to go to great lengths to make sure his patients were not being harmed, and to be tough with staff if he believed they were being unkind.

He admitted he got lots of support, was given the extra specialist staff he needed. "I could virtually get as many Occupational Therapists as I wanted. I ended up with fifteen; I had one, I think, in South Australia." Then there was the programme for psychiatrists in training. It was agreed that most of them would be shared between Callan Park and Broughton Hall. Previously, Broughton Hall had been the "Rolls Royce" of the service. But, with the construction of the Rozelle Admission Centre, it was decided that, so far as trainee psychiatrists and others in training were concerned, the two hospitals and the University of Sydney would share more staff. So he really had some good staff rotating through Callan Park Mental Hospital. With due modesty, Shea argued that "it was fairly easy to make a bit of a reputation".

The superintendence of Callan Park was not allowed to absorb all his time. For example, he accepted an invitation from Professor Maddison to examine candidates for the Diploma of Psychological Medicine of the University of Sydney. He took regular weekly outpatient sessions at "Caritas", which was the special psychiatric day centre and outpatient facility at St. Vincent's Hospital. As mentioned before, he became President of the New South Wales Association for Mental Health. He had made contact with people at Prince Henry Hospital, which was associated with the University of New South Wales, through John Cawte who was attached to the Department of Psychiatry. He played golf at the Prince Henry Golf links, which John Cawte and he and others had carved out of the virgin soil around Little Bay. So, he was widely known by the time Bill Barklay was due to leave for the United States.

The powers that be seemed to be rather keen to have young men at that stage. Shea pointed out that Bill Barklay, "who was their local shining light", was about six months younger than he was. Perhaps, therefore, it was not surprising that they finally said: "Well, Barclay's gone; we'll use you". He did not want to move from Callan Park. In fact, he continued to live there and to commute each day into the Sydney office.

Towards the end of 1965, Brian Shea was faced with another choice. Bill Barclay was due back in Sydney to resume work from the beginning of 1966. Shea expected to return to Callan Park. Then, he received an invitation to dine with Bert Shard, the Chief Secretary and Minister of Health in South Australia, Clem Pounsett, Chairman of the Public Service Board and Lou King, the Under-Secretary, who were in Sydney at some conference. He was told that Bill Cramond had decided to give up the dual role of Director of Mental Health and Professor of Mental Health at the University of Adelaide, which he had been performing for some time, and to concentrate on his academic obligations. The post of Director would become vacant. It was indicated that they would like to see him back in South Australia. He felt sure that the situation had been checked out in Adelaide. Pounsett had probably seen Hugh Birch because they were friends. King and others had no doubt consulted with Bill Cramond to see what he thought. It was half-hinted, too, at the dinner, that they were looking for a potential successor to the Director-General of Medical Services, Dr. J.W. Rollison, who was due to retire in the relatively near future. It was suggested that, as he had had experience in the head office in Sydney, he could find the position interesting. They undoubtedly knew that he was involved in the State geriatric hospitals as well as the psychiatric hospitals, and was expanding into a wider administrative role.

So he returned to Adelaide at the end of 1965, encouraged again directly by Bill Cramond. and then ably supported by Howard Lloyd, who had assumed greater responsibilities for the day-to-day running of the Mental Health Services when Cramond had gone over half-time to the University.

Shea was very modest in regard to his accomplishments as Director of Mental Health Services. He successfully fought hard to ensure that Directors of Mental Health Services were invited in their own right to attend Ministers' of Health Conferences. He was involved with Joe Craig⁴, after the latter's return from

a conference in Scandinavia, in the development of a markedly changed design for Strathmont Centre. He gave lectures and wrote some articles on the training of Mental Health Visitors.

There was no doubt, however, that, at the same time, he was being groomed for the part of Director-General of Medical Services. The Director of Mental Health had always acted for the Director-General in the latter's absence. But, now, Dr. Rollison was passing on to him papers on the development of the proposed hospital at Modbury and, even, the Flinders Medical Centre, with the remark that, "as he wouldn't be around", Shea should perhaps look into them as an early start.

Brian Shea was appointed Director-General of Medical Services just prior to his 39th birthday. He was justifiably proud of this achievement for few, if any, Permanent Heads of Department in the Government had, at that time, been appointed at such a young age. He could see, on the other hand, a disadvantage. If he remained till retirement, he would have been twenty-seven years in the one job. This idea appalled him. It also, no doubt, fuelled a later rumour that he would move into the Federal Government sphere of health.

Brian Shea was fourteen years my junior, when I was appointed to the vacancy created by his promotion to Director-General. The difference in ages never bothered me. From my observations of him in Sydney, I knew he was superior to me as an administrator, and his knowledge of medical services and the politics associated with them so much wider. I sensed that he would support and educate me in these aspects of my job as Director. On the other hand, I had had more experience in the clinical aspects of psychiatry, and my work with the mental health movement and the College of Psychiatrists was more extensive. It is pleasing to record that Shea said that, because he knew he had me there as a psychiatrist in the Mental Health Services, he could concentrate on other areas. He was quite ready to leave the educational programme for trainee psychiatrists, changes to the Mental Health Act, details of building developments in the various hospitals and so on, to me. He was always ready with advice and support and made his officers, like Colin Rankine⁵ and Howard Lloyd, available to me when I needed them. The relationship was a very cordial, constructive and mutually supportive one.

(iii)

I was Director of Mental Health Services from 29 March, 1968, to mid 1978 when I was appointed Director General of Medical Services. The Health Services were in a state of transition. The South Australian Health Commission had been established by Act of Parliament and Brian Shea had become Chairman of the Health Commission. However, some of the functions of the former Hospitals Department had to be carried on until such time as administrative arrangements and legislative changes made it possible for these functions to be subsumed by the Commission. So, a Director General was still needed. I provided the ideal solution: not only had I always acted for Shea when he was on leave; but the fact that I was due to retire in March 1979 presented the opportunity for the position of Director General to disappear with me. At any rate, my appointment provided the Government sufficient time to get its new house in order.

I had many satisfactions in my ten years as Director of Mental Health Services. Some have been alluded to in earlier chapters. There was the satisfaction of being involved in the production of the frozen food for Strathmont Centre, and the extrapolation of the basic eight bed design of the Strathmont villas to other new buildings at Hillcrest and Glenside Hospitals. I had a definite input into the philosophy that determined the shape of a new maximum security hospital to replace Z Ward at Glenside. This story is the subject of the next Chapter. My greatest satisfaction, however, came from the elaboration of an education programme for psychiatrists in training and the evolution of a new mental health act. The fascinating details of how the new mental health act assumed the form it did are recorded in Chapters 10 and 11.

My conviction on the need for training was born during my period of general practice when the exigencies of World War II found me at Murray Bridge after only six months at the Adelaide Hospital as a Resident Medical Officer. It was nurtured when I became a psychiatrist after only twelve weeks at an Army school, which did not adequately fit me for psychiatric practice. I struggled to obtain a senior qualification while managing a private practice and felt at times poorly equipped for the demands made

upon me. My postgraduate experience at the Maudsley Hospital in London reassured me. There remained, however, the awareness that, if the shortage of psychiatrists in South Australia were to be remedied, opportunities for better training had to be provided. This was the spur that drove me, during "World Mental Health Year 1960", to work with the South Australian Association for Mental Health to raise funds to enable the University of Adelaide establish a Chair and Department of Mental Health.

It was not surprising that, upon becoming Director of Mental Health Services, I should build on the foundations of a programme to train psychiatrists started by Bill Cramond in his half-time role of the first Professor of Mental Health.

The New South Wales Institute of Psychiatry had formulated a programme of training which Bill Cramond modified to suit the situation in Adelaide as he saw it. I inherited this. There seemed to me to be two basic problems; how to get the medical graduates to train and where to find the trainers.

I knew from my work with the College of Psychiatrists that there were medical graduates who wanted to become psychiatrists. I also became aware that there were certain medical officers in the hospitals and clinics of the Mental Health Services who were showing little inclination to obtain higher specialist qualifications. The problem was not a shortage of interested people but a shortage of training positions. Though money was not as short in 1968 as it became later, I knew there was little chance of significantly increasing the medical establishment. I needed a strategy to "unblock" existing positions.

It so happened that, as Director, I became a member of the Nurses Board of South Australia. It also chanced that I noticed that regulations made under the Nurses Registration Act provided that at the end of the three year prescribed course of training the student (psychiatric) nurse was given three chances only to pass the examination. What was good for the goose was good for the gander! I therefore recommended to the Public Service Board that, except in certain specific situations such as in the Intellectually Retarded Services, the position of Medical Officer be eliminated, and be replaced by that of Trainee Psychiatrist. The latter position would be tenable for a maximum of five years. In other words, like the nurse, the doctor would have three years to undertake the proposed educational programme and up to two further years to

pass the examination for Membership of the College. In due course, the medical establishment would consist of psychiatrists and trainee psychiatrists.

The Chairman of the Board, Max Dennis, was sympathetic to the proposal. He liked the idea that the positions did not give any permanency, that the plan ensured that medical graduates entered a course of training and then vacated the position after three, or a maximum of, five years. If they passed the examination they could apply for vacant positions of psychiatrist; if they failed, after three attempts, they left the service. I was fortunate to be granted five positions a year for three years, fifteen positions in all. Similar positions were created in the Professorial Departments in General Hospitals. This made a satisfactory rotation of training positions possible and ensured a steady stream of postgraduates.

The next problem - who to train the trainees? Here, my previous experience stood me in good stead. I was like Howard Lloyd: whereas he knew his way about the Public Service, I knew my way around the areas of clinical practice.

On graduation in 1939, I joined the Australian Branch of the British Medical Association which later became the Australian Medical Association. I am still a member. When I went into private psychiatric practice in 1946 there was little opportunity for scientific discourse outside the meetings of this body. There was a discussion group that concentrated on psychoanalytic theory arranged by Harry Southwood⁶. There was also an Australian Branch of the British Psychological Society, of which I was fortunate enough to be able to become a member. When this later evolved into the Australian Psychological Society and became incorporated on 25th July, 1966, I was a Foundation Member. Also, as my work in the Department of Physiology at the University of Adelaide in 1946-7 had stimulated my interest in the physiology of the central nervous system, I joined the Medical Sciences Club at the University. I always took an active part in any organisation I joined. In fact, I was Honorary Secretary of the Medical Sciences Club for one year.

The result of this activity was that I was well-known and well-respected among my medical and non-medical colleagues, both in South Australia and interstate. Always active as a Member of the Australasian Association of Psychiatrists and later a Fellow of the (Royal) Australian and New Zealand College of

Psychiatrists, I made good relationships with those in the academic, public and private sectors of the specialty. I became acutely aware of the schisms that had developed in some other States. Fortunately, Adelaide was different. We were small enough to know one another quite well. We were progressive enough to want to make things better.

I found my teachers in the University Departments, among the staff of the hospitals and clinics of the Mental Health Services, and in the ranks of psychiatrists in private practice. All gave their time and skill willingly. The panel that selected trainees from the medical graduates who applied was made up similarly from representatives of these groups and of the College. We ended up with the best and most successful educational programme for psychiatrists in training in the Commonwealth.

To make all this training possible we needed space for lectures and seminars. Much of this needed space was found at Glenside Hospital, in the century-old, heritage-listed, magnificent administration building. Dr. Lothar Hoff, the Superintendent, was of great assistance in making the arrangements.

(iv)

Born in South Australia, Lothar Hoff graduated in medicine at the University of Adelaide in March, 1953. Unlike some of the medical graduates in this account who came into psychiatry, as it were, by accident, Lothar Hoff approached the specialty in a much more logical fashion. In his opinion, it was a question of supply and demand. As he put it:

"Everybody wanted to be a surgeon. I thought that would be too competitive; whereas I could see that, at least for my life-time, there would be a shortage of psychiatrists."

His decision may have been helped along by John Cawte who came to the Royal Adelaide Hospital and addressed the residents about opportunities in psychiatry. He admitted also that he had a friend in medical student days who had joined the Service the year before. At any rate, when, about the time he

finished his residency at the end of 1953, an advertisement appeared offering positions as resident medical officer in the Mental Health Services, he applied. He was one of about five graduates who came into the system at that time.

In 1954, he started in the Mental Health Services at Enfield Receiving House where John Cawte was the Deputy Superintendent. Such was the shortage of medical staff that, when Cawte went on recreational leave six months after Hoff had been appointed, he was given the responsibility of running the hospital which was the only Public facility in South Australia at that time for the management and treatment of the acutely psychiatrically ill person.

Later that year, he was transferred to Parkside Mental Hospital where he stayed until 1956. Having been, as it were, thrown in at the deep end at Enfield, it was no wonder that he then decided to obtain a senior qualification. In those days, it was possible to sit for a Diploma of Psychological Medicine at the University of Melbourne. But the advice of some of his seniors was to go overseas. He acknowledged that the connection the Adelaide University had with Aubrey (later, Sir Aubrey) Lewis at the Maudsley Hospital in London may have influenced this advice. He spent two years in England working at Nethern and Springfield Hospitals, and obtained the Diploma of Psychological Medicine from the Conjoint Board of the Royal College of Physicians and the Royal College of Surgeons. He returned home in 1960.

Like Cawte, Hoff had found the attitude of senior staff at the Royal Adelaide Hospital discouraging, to say the least.

"All the honoraries said that anybody who did psychiatry was mad - you became like the patients. And you were actively advised not to do this crazy thing."

When he got to Parkside Mental Hospital, Hoff became even more disappointed with the attitude of his seniors - the senior physicians and surgeons, the leaders in the medical profession. There was so much that was so outrageously wrong. There was such gross overcrowding. How could such a poor medical facility be allowed to exist in their community! "And yet the AMA was not interested in that, of course".

Then things began to change. He recalled attending the meeting in 1956 when the South Australian Association for Mental Health was founded and Alan Stoller gave the inaugural address. There was an awakening of public conscience and consciousness. When Bill Cramond came in 1961 he found a group of medical officers in the Mental Health Services, young and inexperienced, but at least enthusiastic and just waiting for things to happen. The Government was being forced to put more money in and Cramond was able to present a structured plan. He had such a great ability to communicate the needs and was so sure how it should be done that he was able to carry the day.

Lothar Hoff was at Parkside Mental Hospital when Hugh Birch retired. He described Birch as a strong and very able man. He was a product of his times which were strong on moral values. It was the end of the Playford era. The hotels closed sharply at six o'clock, gambling was very restricted and there was little Sunday sport. Staff at the mental hospitals were poorly trained and short in numbers. Yet, with many very disturbed patients, Birch was able to run Parkside Mental Hospital during war-time with really a very small staff. In his opinion, Birch was a good organic psychiatrist, with little real sympathy for neurotic people. He had little time for psychotherapy.

On the other hand, as Hoff pointed out, the Annual Reports of the time showed that Birch was able to see the broader issues, like the growing problems of the elderly. However, he seemed unable to take effective steps to address those issues. He got involved with the minutiae of things. For example, at Parkside Mental Hospital, with over seventeen hundred patients, he still expected every application for trial leave to go through his office for him to countersign.

Brian Shea was still Deputy Superintendent to Dr. Birch when Hoff returned from England, but left to become Superintendent of Callan Park Mental Hospital in Sydney in 1962 soon after Bill Cramond took over. Hoff applied for the vacancy and was appointed Deputy Superintendent in the hospital which Cramond had renamed Glenside Hospital. He became Superintendent in 1963. At thirty-five, he admitted he was quite young for the job.

Lothar Hoff considered he was very lucky to have become Superintendent of Glenside Hospital when he did. He considered the first ten years were his best years. Few present-day young psychiatrists have any concept how different it was then. He recalled the rivalry between Hillcrest Hospital to the North and Glenside in the South. But then there was also the Child Guidance Clinic in Wakefield Street, Adelaide. Cramond gave it added support. Hoff remembered he became quite jealous when social workers were encouraged to go to the Child Guidance Clinic instead of Glenside:

"Our needs were great. In fact, sometimes we had to make a deliberate, conscious decision who to concentrate on; to look after the new and acutely ill people or in a relative sense neglect the chronics, because we couldn't spread our resources any further".

However, they were exciting times. New blood was coming into psychiatry. Everybody saw the urgent need for training: first of all, for the training of psychiatrists. Cramond got the training programme going but handed it over to me when I became Director of Mental Health Services in 1968. It was in this regard that Lothar emphasised something that I believe could so easily be overlooked.

"These were also happy times. Adelaide was small and the right size. It had only two major psychiatric hospitals, both within the metropolitan area. Adelaide is a fairly happy place at any time, but it was even better then because of the smaller numbers and the distances seemed even shorter. The private psychiatrists, the salaried psychiatrists and what academics there were then, all got on extraordinarily well. People actually worked together to get the training programme going, and it proved to be a jolly good programme.

There were also the courageous things: like opening up Glenside with limited resources and really very few psychiatrists. There were people prophesying doom and gloom and expecting that patients would run amok and all sorts of things when the restraints were removed. Countering these negative attitudes was the enthusiasm for change; to do away with petty restrictions such as those imposed on visitors. They used to have special visiting rooms where patients were got from the bowels of the hospital and dressed up and brought over for their visitors. And that was only three times a week. Visitors had to go to the front desk and get a little ticket before they were admitted, probably the same procedure they had in gaols."

When the training programmes were extended to social workers, psychologists, occupational therapists and nurses, Hoff supported them enthusiastically and readily made accommodation available at Glenside Hospital. But he most persistently applied his energies to the redevelopment of the substandard wards of the hospital. He regarded as one of his "negative" achievements the closure of Z Ward. He had written in an annual report: "Let's get rid of this terrible place". He was gratified when the Security Hospital Northfield was constructed. He was also gratified when the plans for the redevelopment of Glenside were started and he could vigorously and diligently ensure that the work was kept on target.

Peripheral to his job at Glenside Hospital, Lothar was an active member of the Australasian Association of Psychiatrists and then the Australian and New Zealand College of Psychiatrists. He was at times secretary and chairman of the State Branch. In the early days, the College developed a format for the organization of its Annual Congresses, and a Scientific Programme Committee was established in Adelaide. I was appointed convener and Lothar Hoff and Rayner Smith were the other two members. We all worked harmoniously together to arrange the scientific programmes for a number of congresses. I have already described the significance of this group, especially Dr. Hoff, in my decision to apply for the position of Director of Mental Health Services.

It is probable that my experience in organizing the scientific programmes for the College was of assistance when I set out to plan the educational programme for trainee psychiatrists in South Australia. As already mentioned, candidates from South Australia obtained excellent results in the College examinations for Membership. This was due not only to the high quality of the teaching and clinical supervision, but also to the invention and initiative of Dr. John Clayer, then Deputy Superintendent to Lothar Hoff at Glenside Hospital. He established and arranged a series of trial examinations in the third and final year of their course that put the candidates rigorously through their paces in preparation for the real thing.

(v)

John Clayer graduated from the University of Adelaide in 1959. Like every other graduate at that time, he knew absolutely nothing about psychiatry on graduation. He had 12 hours of lectures from John Cawte but did not have any exposure to psychiatric hospitals or psychiatric patients.

It was not until he worked at The Queen Elizabeth Hospital in 1960, and, as one of his duties, had to attend nurses in the Mareeba Babies' Home, who reported sick, that he came upon illness based on psychological problems. This experience alerted him to similar conditions among the patients in the hospital itself. So he saw John Cawte, who was the visiting psychiatrist to The Queen Elizabeth, about 'a career in psychiatry. Cawte sent him to see Hugh Birch. Birch advised that he come back in about a year's time. In 1961, he approached Hugh Birch again and requested that he be posted to Enfield Receiving House.

However, after three months he was transferred back to Parkside. He had become aware at Enfield, that, if a patient had to be transferred to Parkside for further care, relatives were always very upset, He was feeling somewhat the same as he made his way there.

It was a pretty fearsome place. The wards were separated by high fences and ha-has. There were a lot of shops: there were a boot makers' shop, a tailor shop, a dressmaker's shop - the patients all wore denim outfits which were boiled up by other patients once a week. When patients arrived, their clothes were taken away from them, put in a case and stored in cupboards at the end of the ward. Patients worked in the wards or in these shops or the laundry, the kitchen, the garden or pulling little dog-carts behind them with goods they were taking from one place to another. It was a day of straight-jackets or canvas dresses for the women who tended to tear their clothes; or leather gloves if they tended to scratch themselves. I recall one night when I was on duty I was called to see a woman who was in a straight-jacket that had been tied to the top of the bed to stop

her from getting out of the bed. She had managed to struggle down in the straight-jacket so that it pulled up around her neck and it strangled her. She was dead".

The wards were all segregated. Patients were segregated not by diagnosis but by whether they were male or female and whether they were continent or not in their beds. Consequently, the demented, the intellectually retarded and the psychotic were all lumped together in the wet ward as distinct from the dry ward.

The hospital was still being run by Hugh Birch. Clayer found him a fairly intimidating person. He had trouble with a patient who refused to eat anything solid. The only thing that was not solid was "Farex". So he gave this woman "Farex", so she would not starve, in the early stages of her treatment; and was hauled up before Hugh Birch and admonished for giving food that had been ordered for children, in this case intellectually disabled children.

Parkside was a severe sort of place. The doors to the wards were locked, there were no curtains, no lockers. The toilets in the airing courts were open to the public gaze. It was a very severe environment. Clayer told the story of his becoming concerned at the black specks he was finding in the food served for meals; so he went to the kitchen to enquire. He discovered that the ovens in the kitchen, though recently installed, were pretty old, that they were in fact condemned ovens from the Adelaide Hospital that Dr. Birch had acquired!

Clayer saw the dramatic changes that took place after Dr. Cramond arrived. He used to refer to the work at Parkside as "B.C. - before Cramond" and "A.D. - after his departure". Cramond's ideas were so radical they caused major reactions amongst staff, especially nursing staff many of whom were medical orderlies from the army. They had a very regimented, formal way of doing things and disliked anything that was less formal than they were used to. But Cramond took things very slowly and just watched for the first few months while he sat in as an observer in the administration building at Parkside while Dr. Birch continued his work there. Even after Birch had left he was slow to introduce changes. One of the first things he did was to classify patients by clinical diagnosis and then rearrange the hospital. Psychotic

patients were grouped together, and neurotic patients together. Those with psychiatric illnesses were separated from the intellectually retarded and those with psychogeriatric disabilities. He did, of course, open the doors, which caused a lot of anxiety for everyone, except the patients.

Clayer remembered vividly when Cramond announced that the patients were to have their own clothes. Many of the patients had been in hospital a long time, and the clothes they had come in with were either out of date or would not fit them. So nurses had to take the patients into town to be fitted out. This cost the government, but they did have a full set of clothes from then on. Then the hospital denims and dungeries they had been wearing every day were burnt. It was such a radical thing and it made such a difference. People who had all looked the same in dull grey now had their own personality. They had their own personal things. He bought little cupboards in which they could keep their belongings, often for the first time ever since they had come into Parkside. He put up curtains. There had been no curtains from a fear that patients might hang themselves. He gave wards that had had only rubber cutlery proper metal cutlery.

Of the changes Cramond made the most difficult to bring about was the desegregation of the sexes. Mixing male and female patients was one thing; but who did you have to look after them. Having male staff looking after female patients was a completely new idea. It was done; everything went smoothly and there never was any problem.

When Cramond, as Professor, opened a psychiatric ward at The Queen Elizabeth Hospital, Clayer worked there for a couple of years. He did the Melbourne University Diploma of Psychological Medicine (DPM) during this time. He, Mickleburgh and John Litt⁷ were put up in the Nurses Home at Royal Park Hospital for the three month's residency required by the University. It was an interesting experience, though they all found it difficult as, unlike local candidates, they had not attended any of the DPM lectures given in Melbourne. On his return, he found that Graham Barrow and Roberta Steele, both well-qualified people, had decided to do psychiatry. It was a pleasure to have them at Glenside and, based on his own experience, he set up a small teaching programme to help them to pass the examinations. They both did. As others were coming into psychiatry, he started the practice of getting those who had newly qualified to

teach those who had just entered the programme. Later, he arranged mock exams which were very successful. Other States in Australia followed suit.

Clayer argued that, in the beginning, Cramond was not very helpful; that he supported the idea of formal training but did nothing to get a programme started, that it was not until I became Director of Mental Health Services that the educational programme for psychiatrists in training was initiated. To be fair to Cramond, I had built the programme on work he had already done; and he had stated that, as the newly appointed Professor, his priority was to organize and establish a high quality educational programme for undergraduates, so that psychiatry would become recognised as an integral part of the medical curriculum. Postgraduate education would come next.

The excellent results began to attract top graduates from the Adelaide Medical School; and applications came from medical graduates in other States and New Zealand when it gradually became known that South Australia had such a good pass-rate. So, training took off and never looked back.

Clayer said that, during those years, being in psychiatry was a wonderful experience. He felt a member of a large family, and the support that everyone gave one another was amazing. He recalled that, when he turned fifty, he had a party at which there were many people present from that era. When Issy Pilowsky's wife came in, she said spontaneously: "Goodness! I feel I have come home to my family." It captured that wonderful sense of camaraderie and professional integrity. (In 1991, he felt we were losing that special feeling.)

Clayer admitted that his physical health did play some part in the choice of a career. He was diagnosed as having diabetes at the age of sixteen. He enjoyed surgery very much. However, though he never had any problems, probably because he always kept his blood sugar raised, he was conscious of the fact that having to spend long hours unexpectedly in the operating theatre could pose a serious problem. He admitted that it was this vulnerability, combined with his realization after talking to John Cawte that psychiatry was an exciting and expanding area of medicine, that probably determined his choice.

We discussed whether there had been factors that could have influenced him before he actually developed diabetes. He said that he had read voraciously and written some stories, usually describing personality and emotional attitudes. More important was the sensitivity of one physician. At sixteen, he was shattered when his condition was diagnosed, with the realization of the effect it would have on his life. No more athletics; he would be different. He was struck by how insensitive doctors were of his personal dilemma. But Eugene McLaughlin, whom many students thought of as somewhat odd and eccentric, sat with him and listened and supported and encouraged him. He felt sure that this helped him later to behave similarly towards his psychiatric patients.

John Clayer later was awarded an M.D. from the University of Adelaide. With John Cawte he was only the second psychiatrist in the Mental Health Services to be awarded an M.D. His thesis on diabetes in adolescence showed, I believe, that the quality of the response an adolescent makes to his treatment is proportional to the sensitivity of the physician treating the patient and the nature of their relationship.

(vi)

I believed that I had helped to construct a first-rate postgraduate educational programme for psychiatrists. John Clayer was one of those among many who had made it possible.

In a different area, I was being excited by the construction of a new maximum security hospital to replace the Hospital for Criminal Mental Defectives, the archaic, austere Z Ward, at Glenside Hospital. This not only gave me great satisfaction, but also led to unexpected insights into how a minor legislative change in one Act could greatly modify the requirements of another, a proposed new Mental Health Act.

CHAPTER 9

THE SECURITY HOSPITAL, NORTHFIELD

(i)

In the "Cramond Report" of November 1961, Dr. W.A. Cramond, the Director of Mental Health, had recommended that a new Institution, with adequate grounds and workshop facilities, be built near Yatata Prison to house the criminally mentally ill patients from Z Ward at Parkside Mental Hospital. In a second "Memorandum on the Proposed Hospital for the Criminal Mental Defective of South Australia", to the Honourable the Minister of Health, dated 17 August, 1962, he referred to the need for a facility for the detention, training and treatment of persons with a severe personality disorder:

"With the establishment near Yatala of the Alcoholic Centre and of the Unit for the criminally insane,...we are presented with a unique opportunity in the future of developing a settlement or colony for this group of people who present such a problem to society, many of whom are alcoholics and a number of whom would be patients in the hospital for the criminally insane".

This proposal was not proceeded with. However, on 18 July, 1968, my attention was drawn to this area of need when I had a visit from Dr. Gavin Viner Smith, from the Prison Medical Service, to discuss a plan to construct a new Maximum Security Prison at Yatala. He informed me that Dr. B. J. Shea, the Director General of Medical Services, was eager to have a complete general hospital, with a psychiatric wing, at the proposed institution. The plan was to have maximum security accommodation for 150 prisoners, a block for 50 criminally mentally defective patients and an infirmary for both. The hospital block would also be maximum security. Dr. Viner Smith was keen that there should be dual control: prison officers to be

responsible for security, food and clothing; hospital staff (medical and paramedical) for treatment, care, training and rehabilitation. The Forensic Psychiatrist would be employed by the Mental Health Services, seconded to the Prison Health Service. It would be possible to rotate trainee psychiatrists through the forensic section. He said there was opposition to this concept but that he was pressing strongly for it. We arranged to meet again when the building plans became available.

In December, 1968, I received a letter from Mr. C.R. Lawton, Department of Adult Education, University of Adelaide. It said:

"The Community Education Committee of the S.A. Association for Mental Health has asked Mr. Eric Price (former psychologist at Yatala Prison) and myself to see you about the future plans for housing the criminally mentally ill patients who at present occupy Z ward at Glenside Hospital."

An appointment was made for Wednesday, 18th December. Mr. Eric Price was at the time the Executive Secretary of the John Howard Society of South Australia, a body concerned with prison reform. Following our meeting, he set down his thoughts on the situation as he saw it, namely, that it was the Government's intention to build a maximum security prison on the Yatala property, with two sections to hold long-term prisoners "who were being institutionalised or were considered to be a risk, and prisoners undergoing disciplinary treatment", and a section for the patients from Z ward at Glenside Hospital. In the section for the patients from Z ward, security was to be the responsibility of the Prisons Department, and treatment the responsibility of the Mental Health Services. He went on: "A serious effort to facilitate the return to normality of the patients would appear to require:

- (1) a therapeutic environment;
- (2) Movement to other wards of a Mental Health Services institution as indicated for treatment;
- (3) Involvement of and continuous consultation between the several psychiatrists and other specialists in a Mental Health Services institution in treatment;
- (4) Changing staff at all levels so that freshness, perspective, and new approaches may be provided.

"These conditions are not met in the scheme envisaged.

(1) Any attempt to create a therapeutic environment would be vitiated by the section being part of a maximum-security prison. While maximum security is needed for most of the patients, they should still feel themselves patients, not prisoners, and complete isolation from the prisons (and most of all from a disciplinary section) is necessary for this purpose.

(2) The use of prison guards for security would create a prisoner status rather than a patient status

(3) Movement to wards of a Mental Health Services institution would be hindered, and any day-transfers to such wards rendered impracticable.

(4) The therapeutic effort would be an isolated one, not involving the interest, stimulation, and criticism of the staff of a Mental Health Services institution.

(5) The Mental Health Services staff in the section would have their therapeutic orientation eroded, even if they were not transferred permanently to the Prisons Department."

Mr. Price then argued that a facility for psychiatric cases needing maximum security be retained in a Mental Health Services institution claiming this would not be incompatible with the creation of a therapeutic environment for the other patients. However, he said:

"If it is determined to remove Z ward from a Mental Health Services institution, at least the vitiating influence of the Prisons could be avoided by setting up a separate Mental Health Services institution. This is not impracticable. Prisons Department land at the eastern end of their extensive property at Northfield could be transferred to the Mental Health Services. A separate institution would be more expensive than a section of a larger one, but involve no more extra expense than is being incurred in the separate women's prison for 46 women prisoners now being constructed."

It is interesting to look back on this correspondence., as it was somewhat prophetic in view of what transpired. The first meeting to discuss the erection of the Northfield Maximum Security Prison was held on 7 March, 1969. Those present were Mr. Lloyd Gard, Comptroller of Prisons, Mr. Howard Lloyd, Chief Administrative Officer, Mental Health Services, and Mr. H.T. Pritchard, Project Architect, Public Buildings Department. I was unable to attend. Preliminary sketches were presented, preliminary staff numbers were provided by Mr. Gard, and the possibility of part subsidy by the Commonwealth Government was discussed.

The final minute in the record of this meeting read: "The Australian Mineral Development organisation is acquiring 15 acres of land from the Glenside Hospital site and this could make urgent the vacating of Z Ward hence added urgency to the C.M.D. portion of the Maximum Security Prison".

This was not prophetic. There were two more meetings between the Prisons Department, the Mental Health Services and the Public Buildings Department, at which I was personally present, and then the whole project quietly died.

Nevertheless, it was clear that there was movement in the halls of power and that thought was being given to a replacement for Z Ward. I, therefore, decided to obtain more accurate information on the legal status of patients in the hospitals of the Mental Health Services. The following is a summary of admissions for the month of April 1969:

<u>Hospital</u>	<u>Legal Status</u>	<u>Number</u>
Glenside	Informal	121
	Certified	29
	Custody	4
Enfield	Informal	19
	Certified	13
Hillcrest	Informal	52
	Certified	13
	Custody	2
Total	Informal	192
	Certified	55
	Custody	6

These figures show that for the month of April, 1969, there were 253 admissions, of whom 192 (76%) were informal and 61 (24%) were certified. Of these, six or 10% required security. That is, for all admissions, only six, or 2.4%, needed any security. Extrapolating for the whole of the Mental Health Services for the year 1967-1968, we can say that, of the 2733 total admissions, 2.4%, or 66 patients could require secure accommodation; of the 675 certified patients, 10% or 66, would require security. An actual census of patients in Glenside Hospital, taken at midnight on 1 June, 1969, showed that there were 42 patients in Z Ward, of whom 32 were held under legal authority, either under sections 31, 33,46, 292 or 293 of the Mental Health Act or section 77 of the Criminal Law Consolidation Act. It was clear that the number of psychiatric patients needing maximum security was not high. On the other hand, it was anticipated that, if a modern, yet secure psychiatric hospital were built adjacent to Yatala Labour Prison, prisoners on remand or serving a sentence would be referred for psychiatric assessment and treatment more often than at the time of the survey, when the facilities at Z Ward were so out-dated and inhospitable and the admitting procedures under the Mental Health Act so cumbersome.

At this stage, I think it proper to relate the story of Z Ward at Glenside Hospital and what actually happened regarding its replacement

(ii)

The building that was to become known as Z Ward was, according to Harry Kay in his book commemorating the centenary of Glenside Hospital¹, completed in June 1885. A new dining room annex was added in 1955. It was known as L Ward until 1932 when the name was changed, one reason being that some relatives had complained that the patients were in "Hell" ward.

In the Mental Health Act of 1913, reference was apparently made to Hospitals for Criminal Mental Defectives. Section 16 (1) of the Mental Health Act 1935-1969, which has a marginal note referring to the 1913 Act, read:

"The Governor may, from time to time, by proclamation, declare any mental hospital or any part thereof, or any part of a prison, or any other place which he deems suitable for the purpose, to be a hospital under this Act for criminal mental defectives."

The building, surrounded by a high brick wall with a ha-ha on the inside, was the high security section for the Hospital. Only part of the ground floor of the building was designated as the Hospital for Criminal Mental Defectives. The remainder was used for those male patients whose mental disorder and conduct made them difficult to control in the other male wards.

There is a photograph of Z ward, and of the ha-has, in Harry Kay's book. Though a veritable prison, the design incorporated in the brickwork and the excellence of the brick work itself saved the building from demolition once patients had been moved out. Details of this work are shown in the photograph.

Perhaps, a word or two about the ha-has would not be out of place. A ha-ha was in the form of a trench or a moat on the side of a wall facing the enclosed airing court or exercise yard. This allowed the patients to look over the walls which were only about six feet above ground level, although in actual fact the distance from the bottom of the trench to the top of the wall was more like twelve feet. It was this discrepancy that gave rise to one of the explanations of the name. The story was told that a patient, when being brought into the hospital, noticed that the walls appeared to be only six feet high and commented to the male attendant that it would be dead easy to get over the wall; whereupon, he was greeted with the laconic reply: "Ha-Ha!"

As the photograph shows, entry to the building was obtained through an iron barred gate in the high brick wall. Once inside the wall, the staff member or visitor on official business gained access to the reception area of the ward through a second, locked iron gate. The nurses station was located in this central area, with other administrative offices. A third gate had to be unlocked before the ward proper

could be entered. It consisted of two, double-storied wings, with a wide central corridor, off which the small, single bedrooms were ranged. Each was fitted with a heavy, wooden door with a large lock, with two peep holes, one about five feet and another some two feet from the floor. This arrangement was a relic from the past: the attendant peered through the top hole while shining his lantern through the bottom one.

The floors were made of large slabs of slate. Access to the second floor was gained by an iron staircase. That part of the ground floor, to the right as one entered the ward, was divided from the rest by a twelve feet or more steel grill. This was on rollers and could be moved to divide the section into two variable parts. The part inside this grill was the designated Hospital for Criminal Mental Defectives.

Z Ward was a grim place. It represented the archaic mental hospital at its very worst. The Honorable Bert Shard, Minister of Health, hated the place and would have been happy to have known that it had subsided into a mass of rubble, as the Public Buildings Department had planned, by the skilful placement of a number of explosive charges. Instead, because of its historical significance and the excellence of its brick work, it was placed on the Heritage List and retained. It became the Core Library for the Department of Mines.

(iii)

On 29 March, 1971, I sent a memorandum to the Honourable the Chief Secretary, Mr. A.F. Kneebone, M.L.C., in which I submitted a brief for his approval in principle. The brief had been composed as the result of a number of meetings between representatives of the Prisons Department, Public Buildings Department and the Mental Health Services and referred to the erection of a new Hospital for Criminal Mental Defectives on a site, east of Yatala Labour Prison, with an approximate area of 2.9 acres.

To put the project in perspective, I reviewed the history of the proposal to replace Z Ward at Glenside Hospital. I pointed out that a memorandum on the proposed Hospital for the Criminal Mental Defectives

of South Australia had been submitted to the Minister of Health by Dr. W.A. Cramond, Director of Mental Health, on 17th August, 1962. In 1963, the Director-General of Medical Services, Dr. J.W. Rollison, recommended the establishment of a ward or section for Criminal Mental Defectives at the Yatala Labour Prison. This concept of a Hospital for Criminal Mental Defectives on Yatala Labour Prison grounds was opposed by Mr. R.C.V. Hairfield, Acting Sheriff and Acting Comptroller of Prisons, in May, 1965. This matter was reopened in 1969 when several meetings were held on the design of a Hospital which was to be part of a proposed Maximum Security Prison. As already reported, this project was not proceeded with. The present project had been stimulated by the urgent need to replace Z Ward at Glenside Hospital because of an agreement to cede a section of Glenside Hospital land, on which Z Ward stood, for the erection of a Mineral Sciences Centre.

The site suggested allowed for the provision of security services, as well as catering, laundry and dental services and the use of workshops, by the authorities from Yatala Labour Prison. The transfer of patients to the prison and from the prison to the hospital was facilitated by the proximity of the site to Yatala, while the topography permitted a reasonably open outlook for the patients. The function of the proposed unit was to be a hospital for patients who were committed to be kept in strict and safe custody according to the requirements of the Mental Health Act and the Criminal Law Consolidation Act.

A schedule of accommodation proposed that the hospital be of sixty (60) beds, split up into six units each of ten (10) beds, two on each floor. The preliminary study indicated that a reasonable cost limit would be \$891,000. An important point was that it was believed that the Hospital would qualify for Commonwealth Government assistance under the States Grants (Mental Health Institutions) Act. The proposal was approved.

Because of the time constraints, the Public Buildings Department adopted an unusual procedure for the construction of the Hospital. A Steering Committee was set up that incorporated members of both the private and the public sectors. The Project Manager, the Time/Cost Controller, the Architect, the Structural Engineer, Services Engineer and the Quantity Surveyor, came from private industry; input from the public sector came from the Public Buildings Department, the Hospitals Department (including the

Mental Health Services) and the Prisons Department. The first meeting was held on 14 December, 1971. The intention was expressed at this meeting that the building would be completed before January 1974. Sketch plans would thus have to be complete for submission by the Public Buildings Department to the Public Works Standing Committee at the end of March 1972.

I found this arrangement both exciting and challenging. In February, 1973, I was asked by the Public Buildings Department to record my views on the procedure adopted in the construction of the Hospital. I wrote:

"My work with the Steering Committee has been most satisfying. I feel sure that the free and full discussion with all parties concerned has made possible the early detection of problems and their rectification, and thus assisted in the impressively fast design and construction of the building. I am very much in favour of the procedure".

Patients housed in Z Ward at Glenside Hospital had originally been all male. An early decision had therefore to be made whether the same principle would apply at the proposed hospital. On 11 January, 1972, I sent a minute to the Honourable the Chief Secretary on this matter. I pointed out that, within the hospitals of the Mental Health Services, the old complete segregation of the sexes, with male nurses looking after male patients and female nurses looking after female patients, had been eliminated. There was now a complete integration of the nursing staff with male and female nurses working together under one Superintendent of Nurses, who may be either female or male, and with male and female patients occupying separate wards in the same building. There was no doubt that this integration of male and female staff, and the facilities provided for the social contact between male and female patients in their everyday activities, had improved both the standard of nursing and of patient care and the quality of living of patients within the Mental Health Services.

I was able to reveal that it had been possible to extend this integration of both male and female nurses and male and female patients into Z Ward at Glenside Hospital, in spite of the very real structural difficulties. The same benefits had accrued in this ward as in the other wards of the mental hospitals.

The matter had been discussed with Mr. Lloyd Gard, Comptroller of Prisons, who had no objection to the use of male and female staff, nor to the idea that both male and female patients be housed in this one institution. Finally, I pointed out that, at a meeting at Hillcrest Hospital on 6th January, 1972, between myself, Dr. L.C. Hoff, Superintendent of Glenside Hospital, Dr. W.F. Salter, Superintendent of Hillcrest Hospital, and senior male and female members of the nursing staff of both these hospitals, the unanimous opinion was expressed that we should strive for the same integration of male and female staff and male and female patients at Yatala as had been achieved in the other units of the Mental Health Services. I recommended that, as a matter of policy, approval be given for both male and female patients to be housed in the proposed new Hospital for Criminal Mental Defectives on the understanding that these patients would be cared for by both male and female nurses. I am pleased to say that this recommendation was approved; and to my knowledge no one ever expressed any regrets with this decision.

My own contribution to the design of the hospital was based on a visit I had made to Lake Alice Hospital in New Zealand. At the second meeting of the Steering Committee held on 18th January, 1972, I showed slides of this hospital. On 28th February, 1972, I also visited the Wacol Security Patients Hospital, in Queensland. The observation that impressed me most was that, in the design of both hospitals, more consideration seemed to have been given to security than to the treatment of the patients. The visits convinced me that it was essential to limit the physical manifestations of security (massive steel doors, 2"x2" wire netting cages, the interminable use of concrete and bitumen paving) and to design in such a way as to make the maximum use of the skills of the highly trained psychiatric nurses who would staff the new hospital. It was therefore pleasing to read the following, in the minutes of the meeting of the Steering Committee on 1st February, 1972, in regard to Landscaping: "Outside areas are to generally consist of lawns and shrubs not greater than 3'6" high. Hardstand paving is to be kept to a minimum."

At its meeting on 8th February, 1972, the Steering Committee was advised that, provided the project was approved by the Commonwealth Government prior to the 30th June, 1972, one third of the building costs incurred before the 30th June, 1973, would be paid by the Commonwealth. However, sketch plans and estimates would have to be submitted for approval by 31st March, 1972!

One of the fascinating aspects of this whole project was the way in which the Project Manager, Mr. John Moss, set targets and ensured that the targets were met. There was no doubt, therefore, when he stated on 14th March, 1972, that a draft report and estimates would be presented for approval at the next meeting so that a submission could be made to the Public Works Standing Committee before the end of March, that this deadline would be met.

The plans were approved by the Committee on 28th March. It was estimated that the total cost would be approximately \$825,000. It was also decided that the title of the project be changed to the Security Hospital, Northfield, and that all documents to the Public Works Standing Committee be so titled. A further target was set on 11th July, 1972. It was proposed that, because of the Commonwealth Government subsidy, construction of the building be staged in order that the completion date could be pulled back closer to 30th June, 1973. On the stages suggested, the anticipated completion date would be 30th September, 1973.

The aspect of the planning for the Security Hospital that pleased me, and I believe all those involved, was that human touches were incorporated into what could have been a most sterile and austere building, such as I saw at Wacol, in Queensland. At its meeting on 29 August, 1972, the Steering Committee agreed that curtains should be provided for all bedroom windows to eliminate glare from the security wall; and, on 6 March, it approved the colour scheme proposed by the woman consultant from the architects. In the ward block, the walls were to be off white, the floors light orange vinyl tiles, the ceiling white and the curtains blue/green/purple stripe. The doors and lockers on level 1 were to be purple, on level 2 green, and on level 3 blue. The grilles were to be yellow. The patient day areas were to have lime green doors, deep green polypropylene chairs, and yellow/green/brown stripe curtains; bench tops were to be of maize or navy blue laminex.

On 2 May, 1973, the Committee noted that the Commonwealth subsidy would not continue after 30 June, 1973. The Builder and the Sub-Contractors were informed fully about the cessation of the subsidy and told every effort was to be made in the various workshops to complete as much of the equipment as

possible before the end of June. The total amount of money that was claimed as due for Commonwealth subsidy was \$516,772.

By 8 August, the final roof slab section of the Ward Block had been poured; the Builder was maintaining his schedule in spite of some problems with the plastering sub-contractor, and it appeared that the building would be completed by the end of October. On 12 September, I was able to announce that the official opening date for the Hospital would be Friday, 30 November, 1973, at 3.00 p.m. The estimated contract cost for the building at that time was \$872,016, against the Public Works Estimate of \$963,000.

In my letter to the Director-General of Medical Services in August, 1973, requesting that consideration be given to an Official Opening of the new Hospital, I pointed out that it was a joint venture, which had been planned in close collaboration with the staff of the Gaols and Prisons Department, the Public Buildings Department and the Hospitals Department. The concept underlying the administration of the hospital was that staff from Hillcrest Hospital would be responsible for the care and treatment of patients admitted to it, and that the Gaols and Prisons Department would be responsible for the security of the patients as well as the provision of food and daily stores etc. Because of this, I considered that it would be appropriate that any official opening should involve the two Ministers who were responsible for the Gaols and Prisons Department and the Hospitals Department, namely the Honourable the Chief Secretary and the Honourable the Minister of Health respectively. The Security Hospital was proclaimed in the Government Gazette on 22 November 1973, and the Official Opening was conducted jointly by Mr. A.F. Kneebone, M.L.C., the Honourable the Chief Secretary, and Mr. D.H.L. Banfield, M.L.C., the Honourable the Minister of Health. The first patients, ten patients from Z Ward at Glenside Hospital, were accepted in early December.

We were all very proud of the new Hospital. It therefore came as a disappointing shock when, about the time of the opening, we observed that the grilles over the windows on the three levels of the ward blocks made a natural ladder to the roof. Less easy access to the roof could also be gained, via a natural "chimney" between two walls, by pressing the feet against one wall and the back against the other. An automatic reaction to this observation was to urge that barriers be immediately erected to prevent this. The Standing

Committee considered these matters on 20 December, 1973, and, to my relief, came to the decision that it was virtually impossible to prevent a patient, if he were so determined, from reaching the roof, either by climbing the existing grilles or by getting a hoist from another patient on to the Administration Block and thence up to the Ward Block roof. Echoing my own strong belief, the Committee decided that any form of construction used as a deterrent would more likely draw the attention of the patients to this possibility of reaching the roof; and expressed the belief that, with proper surveillance and the skill of the nursing staff, there would be no need to provide such a deterrent. I am happy to report that this proved to be the case.

The nature of the above problem can be seen in the plans of the Security Hospital², especially the sketches of the north east and south east elevations.

The final meeting of the Steering Committee was held on 24 June, 1974. At this it was reported that the estimated current contract cost was \$924,608, compared with the Public Works Standing Committee estimate of \$963,000. Rarely has a Government building come out under estimate. It was further proof of the success of the procedure used in this venture.

One aspect of the philosophy behind the planning of the Hospital was not achieved. It had been planned that recovered and convalescent patients would use the excellent workshop facilities within Yatala Labour Prison for occupational and industrial therapy. No facilities for occupational therapy were, therefore, provided within the Hospital. Also, it was thought that to spend time in a non-hospital, even * though prison, environment would aid the therapeutic process. Unfortunately, the stigma and discrimination that exist in the outside world in regard to psychiatric patients followed them into the prison. The rejecting attitude of other prisoners and some of the prison officers caused the concept to fail. Cramped and inadequate facilities had to be provided in the Hospital.

CHAPTER 10

THE ORIGINS OF THE NEW MENTAL HEALTH ACT

(i)

By the time I gave my Presidential Address to the Australian and New Zealand College of Psychiatrists in October 1966 the former comfortable attitude I had had to the treatment of psychiatric patients was becoming disturbed. As previously recorded, I entered psychiatry during the Second World War. After being discharged from the Army on health grounds, I spent three years at Parkside Mental Hospital as a medical officer under Dr. Hugh Birch, the Superintendent of Mental Institutions in South Australia. This was at the time when almost one hundred percent of the patients were certified, that is, involuntarily committed. It was also the time when the physical methods of treatment, electroconvulsive therapy (E.C.T.), full-coma insulin therapy and, later, prefrontal leucotomy, were coming into favour. The mental hospitals were full of hope. Patients were actually getting better; patients in the back wards were being re-assessed to ascertain whether they could possibly benefit from the new physical treatments. I gave a number of male patients a three month course of full-coma insulin because they were relatively young and there was just the chance that they could get better. They were all severe schizophrenics of more than two years standing. They did not respond. I had not obtained* their agreement to having the treatment. In my opinion, they were not capable of giving consent anyway. They were mentally ill and incompetent to manage their own affairs. The doctor had to do what was best for them whether it was approved of or not. They had been admitted to the mental hospital as certified patients; the appropriate forms, specified by the Mental Health Act, had been filled in correctly. That was the major requirement: that the proper forms, prescribed by the Act, had been filled in correctly by the certifying legally qualified medical practitioner(s).

If there had been the smallest error in the filling in of any of the three forms, the offending form would have been sent back to the doctor for correction and the correction dutifully initialled in the margin. But, if the patient were properly certified, Dr. Birch had always felt bound to admit that patient, to be given care and protection at least, and treatment where possible.

This mixture of hope-filled therapeutic enthusiasm, plus what amounted almost to a conviction that I knew what was best for the patient, accompanied me into private practice. It was little changed by my two year stint at the Maudsley Hospital, London. When I returned to Adelaide in 1951, I saw little wrong in "encouraging" my private patients to have E.C.T., though this did not apply to full-coma insulin therapy and psycho-surgery. My attitude was modified both by the advent of the psychotropic and antidepressant drugs, which rendered the physical therapies less necessary, and by my increasing interest in the mental health movement.

Prevention became a goal, more important even than therapy. Hope was here, too. We began to talk about primary, secondary and tertiary prevention. Talk abounded with theory. Proven facts were few. Thus it was that I chose a review of the position of psychiatry in a social context as the subject of my Presidential Address at the Third Annual Congress of the Australian and New Zealand College of Psychiatrists in October, 1966. At that time, I had been in clinical psychiatry for over twenty years, and been closely associated with the mental health movement for more than ten.

In an endeavour to draw some conclusions on the perceived status of psychiatry in the community, I reviewed the recorded opinions of people, medical and non-medical, within psychiatry and without. As I did so I became aware that many eminent professionals were very critical of psychiatric theory and practice. This was especially so in relation to unreal claims for the efficacy of treatment and the ability of the specialty to mount effective programmes of prevention. Thomas Szasz,² for example, claimed that there was hardly a human predicament that had not been considered susceptible to psychiatric intervention; and Wootton³ had also questioned "the issues - practical and philosophical and moral - raised by the rapid growth of psychiatric empires, and by the hazy definition of their frontiers". Most concern was directed towards the too close identification of mental health with adjustment. Lord Adrian⁴, for example, had

written of "the danger that too much insistence on mental health will raise a new standard of good, or, rather, of uniform behaviour". Wootton seemed to sum up the concern for me when she wrote: "Fine phrases cannot obscure the fact that adjustment means adjustment to a particular culture or to a particular set of institutions; and that to conceive adjustment and maladjustment in medical terms is in effect to identify health with the ability to come to terms with that culture and with those institutions." Lindner⁵, in his stimulating book, "Prescription for Rebellion", had maintained that the concept of adjustment enjoined men to conform; to adopt an attitude of passivity and a philosophy of resignation. These views had unpleasant echoes in the concepts, also being expounded, on the development of patterns of adjustment behaviour in chronically ill psychiatric patients as the result of the process of "institutionalization".

When I came to consider Psychiatry and the Law, I met further shocks. Psychopathology of an analytic type, with its emphasis on unconscious motivation, had shaken the solidarity of the concept of free will; and blurred the previously clear outlines of criminal responsibility. Such theory was seen as a threat to the traditional distinction between right and wrong. Wootton expressed the criticism this way:

"The present century has seen a notable extension of what is recognized as the sphere of medical authority - with the result that the injunction to render to God the things that are God's and to Caesar the things that are Caesar's is no longer sufficient. Both God and Caesar must now share their empires with the doctor.... In wrestling with the problems of the social deviant, the judge and the priest are increasingly seeking the help of, if indeed they do not actually give way to, the psychiatrist."

Then Sargant⁶ saw fit to write: "Politicians, priests and psychiatrists often face the same problem: how to find the most rapid and permanent means of changing a man's beliefs." Contradictions abounded. Southwood⁷ held that the concern of psychiatry was, or should be, with disease and infirmity, and not with health, however defined. Szasz thundered: "We have, in our day, witnessed the birth of the Therapeutic State. This is the major implication of psychiatry as an instrument of social control".

In spite of these criticisms, I argued strongly and steadfastly that we should demand that it is our right to investigate and treat cases of deviant behaviour and to seek for the causes of these forms of conduct; for our knowledge, though far from complete, was at least sufficient to render legitimate such a demand. I said that, in matters social and legal, psychiatry should not remain silent just because its propositions might offend some segments of society.

Nonetheless, my previously comfortable views that had justified therapeutic intervention, essentially on the grounds that it was in the patient's best interests, had been shaken. Kittrie's book, "The Right to be Different", clarified many of the issues and confirmed my unease.

Kittrie⁸ had pointed out that the sense of responsibility that a community felt towards its less fortunate citizens was based on the role of *Parens Patriae* which had been decreed by the Anglo-Saxon King Aethelred the Second (nicknamed "The Unready"): "If an attempt is made to deprive any wiseman in orders or a stranger of either his goods or his life, the King shall act as his kinsman and protector..... unless he has some other". Mental health ideals undoubtedly grew out of this concern. However, the *Parens Patriae* power can become suspect when reformatory and therapeutic zeal becomes too enthusiastic and crusading. The laudable desire to protect a mentally disordered person from the legal consequences of his actions, or a family from distress by providing treatment under involuntary commitment to a mental hospital, may cast the "sick" into a more dangerous and potentially punitive situation than the criminal, who is subject directly, not only to the sanctions but also to the protection of the Law.

I argued, in my Presidential Address, that the dilemma in which the psychiatrist found himself, when faced with considerations of law, was really the dilemma of society, that society, in its evolutionary need to solve its conflict between punishment and forgiveness, had been forced to seek a psychiatric deliverance, and the psychiatrist had been invited to displace the priest in begging for men's souls. In generous vein, Wootton had admitted that the medical treatment of social deviants had been possibly the most powerful reinforcement of humanitarian impulses.

So, when I was appointed Director of Mental Health Services in February, 1968, I had vaguely formed ideas on the human rights and civil liberties of the mentally ill and intellectually retarded and an awareness of how they were being denied. Then, I became aware of other misgivings that were beginning to surface. I recall receiving a question from the Labour Party in South Australia asking why the certified mentally ill were not provided with a printed statement of their rights such as was provided to prisoners. The Scientologists were becoming active, espousing especially the views of Thomas Szasz: "Do we want to become a regimented nation, brain-washed and brain-fed through a powerful army of psychiatrists?" Fortunately, my work with the South Australian Association for Mental Health had given me an inkling that these misgivings were around.

(ii)

In June, 1970, I presented a paper at a clinical meeting at Glenside Hospital in which I attempted to clarify my thoughts on "Mental Health and Human Rights". I started by pointing out that, in the early days of South Australia, the mentally ill were housed with the criminal in the Adelaide Gaol. There was little distinction, therefore, between the mad and the bad. Later, the mad were transferred to the Adelaide Lunatic Asylum and, in 1870, to Parkside Lunatic Asylum. Though their mental illness was thus recognized, the patients were still incarcerated in a prison-like building as if they were still criminal. Only slowly the distinction between the mad and the bad was clarified. Unfortunately, the South Australian Mental Health Act 1935-1969 still dealt with the mentally ill as if they were bad.

We can now recognize, I continued, that the mad can sometimes be bad, Two women, who murdered their children and then took their own lives, were examples of bad actions occurring in people who were presumably mentally ill. However, most of the mad do not behave in such a bad fashion. Sometimes, the bad may be diagnosed as being mad; but, very frequently, the bad do not fit into any known category of madness.

Mental hospitals, by lowering the walls and removing locks from the doors and bars from the windows, had become more like the hospitals that treat physical forms of illness. Unfortunately, the laws that applied to the mentally ill, still reflected those archaic attitudes in which the confusion between the mad and the bad was still evident. The fact that, under the Mental Health Act, the police could apprehend and detain a person, who was only apparently mentally ill, cast doubts on whether the intention was that the person be committed to hospital for their own good or for the convenience and in the interests of the community. George Sharman, then Senior Guidance Officer (Special Education) in the Psychology Branch of the Education Department, and a great supporter of the South Australian Association for Mental Health, had drawn attention to "the gross infringement of the civil liberties of a citizen contemplated by the Act".

I referred to the concern shown for the way in which mental health legislation may involve the doctor in the restriction of the civil liberties of the mentally ill or the intellectually retarded person. Ullman⁹ in 1967, for example, had noted that a person comes to a psychiatric hospital because someone, who is powerful enough to have his way, wants to change the patient. That person may be the patient himself, his relatives, employer, or the police. The important thing is that it is not the medical diagnosis that involves committal of a patient to a mental hospital; it is the behaviour which may, or may not, be a symptom of that illness. This latter point seemed to me to be particularly relevant. Szasz had already written in 1964 that, though the contemporary psychiatrist is confronted by a bewildering variety of problems, these problems all share a common feature: in each case there is a conflict between people. This fact, he argued, explained the psychiatrists's basic dilemma; which side of the conflict should he take and whose interests should he support? I, like most doctors, would deny that I took sides in any conflict, and that my primary and only responsibility was other than to be a doctor to individual people. But I was beginning to see that, when I certified a patient to hospital, even though I felt it was necessary for the treatment of his mental illness, I was somehow acting also in the interests of others. It was becoming clearer to me why more and more people were showing concern for the civil rights of the mentally ill.

I therefore set out to examine the mental health legislation in South Australia and the power it gives doctors to interfere with the rights and freedom of individuals on the basis of a medical diagnosis of mental illness or mental defect.

As a beginning, I asserted that the patients in the Receiving Houses and Mental Hospitals in South Australia fell into three broad groups. The first was constituted by those patients who suffered from some form of psychiatric illness that required treatment. This group included the majority of psychiatric patients. They mostly sought treatment voluntarily. Some, because of the nature of their illness, were reluctant to accept treatment, but, once in hospital, made rapid progress and were then willing to continue with their treatment.

The second group comprised the intellectually retarded and the demented elderly. Some socially dependent, chronically mentally ill persons could also be included. In most cases, there was little justification for certification. The majority of the intellectually retarded and the socially dependent could live at home or in hostels; demented old people and the severely retarded could be cared for in nursing home type accommodation.

The people in the third group did not fit into any one medical category. The unifying feature was the conduct of the individuals concerned. The person could suffer from a psychiatric illness, be elderly or intellectually retarded; or manifest a psychopathic (sociopathic) personality disorder. Such people could find themselves in a mental hospital or even be committed to the Hospital for Criminal Mental Defectives. The psychopath could just as likely end up in jail. In this category, the psychiatric diagnosis had no relevance. Legal requirements took precedence and the public interest was of primary concern. Detention and control were demanded.

Unless there could be a clear differentiation between these three categories, there was little doubt, in my opinion, that the psychiatric patient was at a disadvantage by comparison with someone suffering from a physical illness. Because of the difficulty of communication that often existed with persons of disturbed mind, and the close relationship between mental illness and disorders of behaviour, it was perhaps not

surprising that the erroneous belief had emerged that the mentally ill were a danger to themselves and to others. By comparison, those suffering from a physical illness were considered to be capable of rational judgment. Little wonder that the mentally ill became constrained by legislation based on these archaic concepts.

The South Australian Mental Health Act, 1935-1969, was a good example. Of the 173 Sections, only four (Section 31, sub-sections 1 and 2; Section 35, sub-sections 1 and 2; Section 37, sub-sections 1 and 3, and Section 137) could be construed as referring to the treatment of psychiatric disorders. Only Section 137 accepted psychiatric patients as sick people who, in the majority of cases, could be treated in hospital in the same way as the physically ill were treated. Sections 31, sub-section 1, and Section 35, sub-section 1, did not refer to treatment: the emphasis was on the patient being "received into and detained". The remainder of the 173 sections were legal provisions that justified the need for detention and for control, while at the same time providing some safeguards against wrongful detention and control.

The opinion I expressed was that it was this emphasis on reception into and detention in a mental hospital rather than on treatment that had struck fear into people in the past, and had encouraged the persistence of the stigma that had been associated for so long with mental hospitals. The Act empowered doctors, admittedly by completing correctly the appropriate schedules, to deprive the patient of his civil liberties on the basis of a psychiatric diagnosis.

It became clear to me as I composed this paper that, over time, I had been swinging round to some of the views expressed by Szasz and others, namely, that when a doctor decided to coerce his patient into treatment, even if the action was empowered by the Mental Health Act and could be justified as being in the patient's best interests, he acted in a way different from the way he would in any other form of medical illness. He acted as an agent of society. I believed that this power could have the effect, not only of changing a doctor's attitude to the patient suffering from a mental illness, but also of making patients apprehensive of seeking treatment for such an illness. I argued, therefore, that new mental health legislation should endeavour to distinguish clearly between concern for the mentally ill person and the need for treatment, and concern for the peace of mind and the safety of others.

Following this review, I presented my ideas on a New Mental Health Act. I argued that the treatment of psychiatric patients should be totally divorced from any legal demands for detention and control; and that this distinction should be made clear in the form of the Act. Provisions for treatment should not be swallowed up in those for detention and control. My opinion was that a Mental Health Act should clearly differentiate between persons admitted under certificate for treatment and care in their own welfare and those committed in the public interest.

I then went on to state that a medical practitioner should be responsible only for the care and treatment of his patient. In the community, the doctor would be responsible for referring a patient to hospital for the treatment of a disorder that was diagnosed on the basis of a medical, and not a legal, classification of mental illness; and the doctor in the hospital would be responsible for the care and treatment of his patient and not for his detention and control, beyond that already reasonably exercised in the treatment of certain physical disorders such as, for example, the restraint of a confused patient in the wards of a general hospital following a severe head injury.

Appropriating some ideas that Bill Cramond incorporated in his so-called "Cramond Report"¹⁰, I suggested that a new Mental Health Act should make provision for four different types of treatment units:

1. Hospitals for the care and treatment of patients suffering from psychiatric illness. Such a hospital would be defined, if any definition were required, as one with the facilities to treat psychiatric patients. Such a hospital could be the psychiatric ward of a general hospital, the open wards of hospitals of the State Mental Health Services, or a private psychiatric hospital.
2. Special Hospitals for the detention and control, as well as the care and treatment, of those persons committed in the public interest. Such an institution would be proclaimed under the Act.
3. A Hospital for Criminal Mental Defectives.
4. A Psychopathic Hospital for offenders suffering from abnormally aggressive or seriously irresponsible conduct, the psychopathic (or sociopathic) personality disorder.

I pointed out that, under such a codification of facilities, the existing wards of the Mental Health Services would become predominantly places of care, comfort and therapy, where the psychiatrist, as in a private hospital or the psychiatric wards of a general hospital, was free to follow his primary role of treating patients. The great minority of patients, not more than 2% of admissions, whose disturbed conduct necessitated their detention and control in their own or the public interest would not be admitted to these wards, but to a separate institution, the Special Hospital, referred to above.

Attention was then given to the form of medical certification that would make this kind of segregation possible. I believed that medical certification should be restricted to the compulsory admission of a patient who required care and treatment in the interest of his own health and welfare. Any other form of detention and control should be by judicial procedures.

I recommended that the only medical certificate should be in the form of a Treatment Order, which would be valid for seven days from the date of admission, but which could be extended by two additional separate periods of seven days on the recommendation of the Superintendent of the Hospital. A Treatment Order would secure a patient's compulsory, though temporary, admission to a hospital in the first category above.

Where detention and control in the public interest were concerned, the procedure should be judicial and involve appearance before a magistrate. The magistrate or judge, acting on the evidence presented to him, including the advice of two legally qualified medical practitioners, would issue a Reception Order, which would secure admission to the Special Hospital defined above.

If a person were admitted to a hospital on a Treatment Order and did not respond to treatment or settle down satisfactorily within the specified 21 days, or became unmanageable in an open ward setting, or was considered by the Superintendent to constitute a danger to others, he could be committed to a Special Hospital by a similar judicial procedure. Where a hearing before a magistrate or judge could not be arranged quickly enough, I recommended that the Superintendent of the Hospital be empowered to issue a Temporary Reception Order, valid for up to one month, authorizing the patient's transfer to the Special

Hospital; but the subsequent detention of the patient would be determined by the enquiry of the magistrate or judge.

Because the Special Hospital was a closed security institution, I argued that the patients would require safeguards, such as appeal to a Mental Health Review Tribunal.

All reference to Criminal Mental Defectives should be removed in a new Act, except in so far as it might be necessary for the definition and proclamation of a Hospital for Criminal Mental Defectives. It was my view that offenders requiring detention and control for psychopathic disorders should be dealt with under amendments to the Criminal Law Consolidation Act and not in a new Mental Health Act. The care and treatment of this group should be undertaken in the separate institution already referred to.

In concluding the paper, I pointed out that, though passing reference had been made to the intellectually retarded, it was my view that the intellectually retarded must be considered completely separately from the mentally ill; that a Mental Health Act should be concerned only with the mentally ill. The great majority of the intellectually retarded required education, oversight and care. This could be better provided under different legislation. It seemed to me that the only instance in which the intellectually retarded person would require detention and control in the public interest would be where his/her conduct offended against the law, and such a person could be dealt with, as suggested above for mentally ill and psychopathic offenders, under amendments to the Criminal Law Consolidation Act.

The paper was well received and provoked considerable discussion and comment. I felt encouraged to pursue further my studies of human rights, civil liberties and mental health legislation.

About this time, and in the ensuing months, two other significant things were happening. The National Health and Medical Research Council became interested in the possibility of establishing uniform principles of Mental Health Legislation; and Timothy George, a final year law student, began enquiries in order to write a thesis on the existing Mental Health Act. It will be pertinent to examine each of these developments in turn.

(iii)

Since Federation, government responsibility for health services has been divided between the State and Commonwealth Governments, though historically the State Governments have played the major role. From the end of World War II, the Commonwealth Government assumed an increasing responsibility in health care.

The provisions for mental health care were entirely a State responsibility until 1948. In that year, the first direct approach by the Commonwealth Government was made when The Mental Institutions Benefits Act was passed which provided a small cash benefit to the States for the maintenance of patients in mental hospitals.

The Commonwealth Government involvement in the provision of both health and mental health services has been in the area of financial assistance to the State Governments who retained the responsibility for the provision of the services. However, since 1973, this financial power of the Commonwealth (which collects all taxation revenue and disburses a proportion to the States) has been used to push development in certain directions: such as, to encourage the provision of community based services, , and to discourage the persistence, let alone the growth, of the mental hospital system.

Mental health legislation has always been a State Government prerogative. However, the Mental Health Committee of the National Health and Medical Research Council (NH&MRC) at its meeting in July 1970 discussed the need to establish principles for uniform mental health legislation. As a member of this Committee in my position of Director of Mental Health Services for South Australia, I submitted a paper to this meeting, entitled "The Mental Health Act of South Australia 1935-1969 and Human Rights". It was based on the paper just reviewed. Dr. Gordon Urquhart, the Director of Psychiatric Services for the State of Queensland, had also written a paper. It was not surprising, therefore, that Urquhart and I,

together with Dr. Brian Hennessy, the Director of Psychiatry in the Australian Capital Territory Health Services Branch, Commonwealth Department of Health, Canberra, were nominated to form a working party to prepare an outline for presentation at the next meeting of the Committee to be held on 18 and 19 February, 1971. Hennessy was to be the convener.

On 18 January, 1971, Brian Hennessy wrote and suggested that "we should make some comment as to the feasibility of uniform legislation - it does seem difficult in detail, because of other connected and very different legislation in each State". In response, I made the following points in favour of uniform legislation:

1. A uniform nomenclature would appear to be desirable. Words such as "certified, committed, restricted, recommended" are used in State Acts to describe legal processes which are similar if not identical. This leads to confusion and uncertainty. Uniform nomenclature would define clearly throughout Australia the precise areas in which the law imposes restriction of freedom on the individual psychiatric patient.

2. Discussions on uniform legislation could lead to a clarification of the unsatisfactory situation that exists at present in the relation between legal concepts and psychiatric conditions. A legal classification based on the need for security or restraint has no clinical meaning and is irrelevant to patient care. The coexistence of a legal and psychiatric classification has given rise to opposition in some quarters to the whole modern concept of psychiatric care.

3. Uniform legislation, by taking note of this point of view and resolving the problem so posed, could do much to remove the prevailing, though lessening, fear of committal to a psychiatric hospital and the stigma associated with this in the public mind.

4. Because of differing legislation in the various States of the Commonwealth, the transfer of patients across State boundaries creates unnecessary difficulties. For example, a patient certified in the Northern Territory, if transferred to South Australia, has to be met by the police in Adelaide and taken before one or two doctors, depending on whether he is to be admitted to a Receiving House or a Mental Hospital, and recertified. Uniform legislation would make such transfer of patients less complicated.

5. The method of controlling and safeguarding the financial assets of a certified patient would appear to vary considerably from State to State, and each Act has its own particular category

of officer who is responsible. For example, in South Australia the Public Trustee is the responsible officer, but a patient's affairs are placed in his hands only on the recommendation of the Superintendent of the Hospital. The control of a patient's affairs may be looked upon as an infringement of his rights and so contribute to the scarcely veiled hostility of a section of the community to the whole concept of certification. Differences in legislation from State to State could aggravate, whereas uniformity of legislation may lessen, this attitude.

Points I made against uniform legislation were:

1. It may be argued that, as the care of the mentally ill is the responsibility of the individual State, each State should have the right to legislate independently.
2. Each State has different problems dependent on the size and distribution of population, the availability and accessibility of psychiatric hospitals, clinics and outpatient departments, and the relationship of the law and social welfare to the psychiatric services. Uniform legislation would be unable to take all these factors into account.

A draft working paper was prepared by Dr. Brian Hennessy and presented to the Committee in March 1971. This paper combined the sometimes different views of Gordon Urquhart and myself, though on the whole there was a unanimity of views. The main area of disagreement was related to the powers of a medical practitioner. Dr. Urquhart believed strongly that it was a doctor's responsibility to care for anyone who was mentally ill. But he went further and stated that there should be "statutory provision to enable a medical practitioner to examine a patient who he suspects could be mentally ill". To this end he proposed that legislative provision be made so that a medical practitioner could initiate the action and obtain the effective assistance of a member of the Police Force to compulsorily examine a patient where he had grounds to believe the patient may be mentally sick. I objected because I felt that this put the doctor into the position of acting possibly as an agent of society and compromised his therapeutic role.

This document¹¹ was discussed at length over a number of meetings of the Standing Mental Health Committee. A final statement was presented to the meetings in March and September 1972. It then went to the National Health and Medical Research Council itself. There was little action on the document, till

the Committee was informed of some concern the Commonwealth Minister of Health, Dr. Doug Everingham, had on this matter. I cannot recall the basis of this concern; but, in September, 1974, it was reported that the National Health and Medical Research Council had amended the recommendations of the Mental Health Committee to underline its conclusions that the situation in the States was satisfactory and suggested that the matter be raised at the next Health Ministers' Conference, when the possibility of an ombudsman could be introduced. So the matter of uniform mental health legislation was quietly buried. Nevertheless, the deliberations of the Committee constituted an enlightening and educational experience, and stood me in good stead in my own grappling with the South Australian Mental Health Act.

(iv)

Mr. T.S. George, a student in the Faculty of Law, University of Adelaide, critically examined the criteria for admission and discharge in the South Australian Mental Health Act 1935-1963 for his honours thesis in 1971. He claimed that legal aspects of involuntary hospitalization of the mentally ill received very little attention in South Australia. This was surprising when the large number of people involved was considered. Further, litigation by anyone claiming to have been wrongfully detained was virtually non-existent. He believed that the lack of controversy surrounding this important issue could be attributed, at least in part, to the fact that the compulsory powers conferred on doctors and justices by the Act had been very rarely abused.

However, it was surprising that commentators interested in civil liberties had been notoriously quiet on the subject of compulsion, because committal to a mental institution entailed a definite loss of personal liberty. He suspected that the mere classification of commitment procedures as "civil" (as opposed to "criminal") and the acceptance of the purpose of hospitalization as being therapeutic (and not punitive) had been the main reasons for the apathy. This apparent faith in psychiatry was reflected in the commitment laws. He went on:

"(The) law affords much less protection to a patient hospitalized against his will for life than to the most minor offender in the sphere of criminal law. Whereas the criminal has a huge body of procedural safeguards and evidentiary rules in his favour, the mental patient may depend for his liberty on the opinion of a doctor."

George discussed the inability of psychiatry to define mental health and mental illness. In spite of this, in many jurisdictions, a finding of mental illness alone was sufficient ground for commitment to a mental institution. As an example, he pointed out that a person could be hospitalized under section 31 of the Mental health Act simply if he were certified as being a "mentally defective person", without any further requirement that the person was dangerous or that there was some sort of prediction that treatment would be beneficial. He submitted that, given the difficulty with defining mental illness, the mere classification of a person as being mentally ill was an inadequate basis for commitment.

"A more sensible approach to the question of commitment of the mentally ill would be to ascertain what grounds justify the use of compulsory powers, and then ask whether the patient in question is encompassed by one or more of these grounds. The grounds most commonly cited as justifying commitment arise when a person is dangerous or is in need of treatment."

The concept of "dangerousness" was considered at length. George drew attention to the pitfalls inherent in predicting dangerousness and referred to a "growing body of U.S. writers" who regarded preventive detention as a result of psychiatric predictions as an increasing threat to personal liberty. None-the-less, he agreed that involuntary commitment would be appropriate where a person posed a threat of injury to himself. He was less positive in regard to procedures for commitment in the public interest and believed they should only be instigated where there was a high degree of risk of bodily violence; for "despite popular opinion to the contrary, the number of dangerous mental defectives (was) very small, and nearly all of them (were) criminal mental defectives".

With regard to the other common justification for compulsory hospitalization, namely the need for treatment, he pointed out that there was no justification for committing a person on these grounds if, in

fact, no treatment was given once hospitalized. Also, there was less agreement for the justification of involuntary commitment for treatment. Some psychiatrists even suggested that hospitalization should never entail compulsion; others seemed ready to commit just as soon as the patient showed signs of mental illness. The type of provision contained in mental health legislation, including the South Australian Mental Health Act, gave an unlimited discretion to the doctor, and made a successful challenge to a wrongful commitment very difficult.

George then submitted that a commitment law should take into account the following factors, all of which should be satisfied before commitment could be authorized:

1. The person should be mentally ill.
2. The personnel who commit should believe that treatment (would) be given and (would) most likely result in an improvement.
3. The person's mental condition should be such that he (was) unable to make a rational decision about his own hospitalization."

As will be seen later, these views had a significant influence on my thinking. The same may be said in regard to his discussion of the need for adequate procedural safeguards. George stated that these were a question of balance. It was quite possible for safeguards to be excessive, such as the use of a jury trial in certain American States; on the other hand, they could be too few, especially if one recognized the important non-medical aspects which must be taken into account. He quoted a position taken by the World Health Organization Expert Committee on Mental Health:

"No matter what the composition of the body which authorizes compulsory detention may be, its purpose should always be to decide on the legality of the detention of the patient in hospital. It need not be, and should not be, to certify that a patient is insane or mentally sub-normal. The distinction between the authorization of detention and the certification of an individual's state of mind is an important one."

George also pointed out that, as involuntarily committed patients tended to stay longer in hospital than voluntary patients, the need for review procedures in South Australia was compelling. There should be the opportunity for a patient to submit an application to a review tribunal.

Most of his criticism was directed to those sections of the legislation that dealt with criminal patients. Criminal mental patients were regarded far differently from the civil patient; they were housed in a more secure institution, and it was more difficult for them to persuade the hospital authorities that they were fit to be released. They could be committed under certain provisions of the Criminal Law Consolidation Act or under section 46 of the Mental Health Act. Each of these provisions was examined in detail.

Regarding the first, George concluded that, once a prisoner had been acquitted on the grounds of insanity and detained in a mental hospital, he would experience great difficulty in obtaining his release. A successful invocation of the insanity defence provided great scope for preventive detention. Section 46 of the Mental Health Act provided a second method by which a prisoner could be detained in the hospital before he stood trial. It allowed for a person under commitment for trial for any offence to be removed to the Hospital for Criminal Mental Defectives if a doctor certified that he was mentally defective and if the order was signed by the Minister, and kept there until, under section 49, the Director of Mental Health, or the superintendent and another medical practitioner, certified that he was no longer mentally defective. The fact that the prisoner was capable of standing trial was considered irrelevant. George considered that this was one of the most serious anomalies in the Mental Health Act for it meant that a person, who had never been tried, was subjected to indeterminate detention irrespective of the gravity of the offence with which he had been charged. (The anomaly was made even worse by a determination of the then Crown Prosecutor, Mr. E.B. Scarfe, who told me personally that, even though a prisoner may have responded satisfactorily to modern drug therapy in a clinical sense, he would still be mentally defective by law and so be unable to stand trial because, in the terms of the Act, he would not require drugs if he were no longer mentally defective.) George argued that he could see no justification for detention of this sort and submitted that section 46 should be repealed.

In conclusion, Timothy George admitted that he might have painted too gloomy a picture of commitment in South Australia. The substance of his allegations concerned the looseness of the existing laws and the potential they created for wrongful commitments, though it was difficult to assess the extent to which wrongful commitments had occurred. He did find some criminal cases which he considered called for urgent review.

One such case was that of a man, who was charged with attempted murder in 1957. He was removed to Z Ward, Parkside Mental Hospital, before standing trial, and was still there when interviewed by George in April, 1974. He was receiving no treatment or drugs. George wrote of him:

"I am unable to comment on his mental condition, yet after a forty-minute interview with him I left with the impression that he was fit to stand trial. His recollection and comprehension of the events surrounding the alleged crime were good, and I believe his ability to conduct a defence and follow court proceedings was above average. [He] challenged the legality of his detention in 1961 (he sought a writ of habeas corpus) but he failed because he was still mentally defective and so could not be discharged under section 49. His ability to stand trial was not considered.

"I can see no justification for detention of this sort. The rationale for commitment of people found unfit to stand trial is that it would be unfair to convict a man who is unable to present information which might convince the court to decide in his favour. Conversely, it is unfair to deny a trial to a prisoner who is both willing to stand trial and is capable of conducting a defence."

The facts of this case strongly influenced my own view of the Mental Health Act 1935-1963, for it was brought to my attention, as Director of Mental Health Services, when the man was found hanged, on the Mt. Osmond Golf Course, on 2 October, 1971. He had actually managed to escape from the maximum security Z Ward some days before. It could be argued that his death was a consequence of his mental illness, because, as George had pointed out, he was certified as being mentally defective. My own view, after reading his case notes, was that, following his escape, he sought help to secure his freedom to face trial and had been advised that the only thing he could do was to give himself up to the authorities. This would mean his return to Z Ward. I believe he found this choice impossible to accept, and decided instead to end his life. I do not know whether my assumptions were right or wrong; I do know that I found the whole issue

of his certification, his being held in Z Ward, without trial, for some fourteen years, and the failure of his attempts to be heard, most disturbing. So, when I received George's paper, I agreed whole-heartedly with his recommendation that the Act needed review.

CHAPTER 11

THE EVOLUTION OF THE MENTAL HEALTH ACT

(i)

The paper by Timothy George, based on his Honours thesis, was published in 1972¹. As I pointed out in a memorandum sent to the Director General of Medical Services, Dr. B. J. Shea, on 12 February, 1973, George acknowledged the considerable time I had spent discussing his work with him, correctly stated that I agreed with his statements in general, and mentioned that I had given much thought to those changes in Mental Health Legislation which I considered desirable.

Two events delayed any action on my part. The first was the establishment of the Committee of Enquiry into Health Services in South Australia² which had brought down its report. If carried out, the recommendations of the Committee pointed to the eventual virtual elimination of the Mental Health Services as then constituted, and implied a need for significant changes in legislation. The second event was the setting up of the Criminal Law and Penal Methods Reform Committee³. I understood that this Committee had considered relevant sections of the Mental Health Act and the Criminal Law Consolidation Act in detail.

I had made submissions to both these Committees and believed that no legislative changes to the Mental Health Act should be contemplated until the Criminal Law and Penal Methods Reform Committee had brought down its findings and the full implications of the report of the Committee of Enquiry into Health Services in South Australia had been examined.

However, earlier consideration had been given to the possible changes of legislation that might be necessary in order for the Security Hospital, Northfield, to function in the flexible manner envisaged in its planning I had met with Mr. K.P. Duggan, the Crown Prosecutor, and Mr. Lloyd Gard, Comptroller of Prisons, on 19 July, 1972, followed by a number of informal meetings. In a memorandum to the Crown Solicitor on 3 April, 1973, Mr. Duggan gave an opinion that no change in legislation would be required for those patients who came under the provisions of the Criminal Law Consolidation Act, namely: persons convicted by the Supreme Court, District Criminal Court or Court of Summary Jurisdiction of an offence of a sexual nature and ordered to be detained in an institution during the Governor's pleasure; accused persons tried by a jury and found not guilty on the ground of insanity, and accused persons charged with an indictable offence and found insane by a jury so that they could not be tried on information. In both latter categories, the Governor was empowered to order the safe custody of persons so found, during his pleasure, in such place and in such manner as he thinks fit. The Security Hospital could be used as the place of detention, so long as it was proclaimed a Hospital for Criminal Mental Defectives under Section 16 of the Mental Health Act, 1935-1969. A simple, uncomplicated solution was provided for those persons, under sentence or awaiting trial or sentence, who whilst in custody were certified mentally defective under section 46 of the Mental Health Act, and removed to the Hospital for Criminal Mental Defectives. This was the contentious section of the old legislation to which extensive reference will be made later. Mr. Duggan suggested that section 31 of the Prisons Act be amended so as to give the Comptroller of Prisons a specific power to remove a prisoner to the Security Hospital, if it were desired that he should have this power. This could be achieved by inserting the words "or for the purpose of psychiatric observation or treatment" after the word "illness" in section 31(1) of that Act.

No.74 of 1973, "An Act to amend the Prisons Act 1936-1972" provided for the striking out of the passage "in case of illness" and inserting in lieu thereof the passage "for the purpose of medical, psychological or psychiatric examination, assessment or treatment".

The Act was assented to on 6 December, 1973, and the amended section read:

"The comptroller may remove any prisoner from any prison under his control to any other prison under his control, and for the purpose of medical, psychological or psychiatric examination, assessment or treatment, to any hospital, infirmary, or other institution, as occasion may from time to time seem to him to require."

This legislative change made it possible for prisoners on remand to be admitted for psychiatric observation and assessment, and prisoners serving sentences of imprisonment to be given psychiatric treatment should the need arise. Transfer in and out of the Security Hospital could be effected, without any fuss or bother, by the Comptroller of Prisons on the recommendation of the Forensic Psychiatrist.

It also resolved the question of how prisoners were to be admitted to and discharged from the Security Hospital, and removed some of the objections that Timothy George had most strongly levelled at the existing Mental Health Act. A whole section of the Mental Health Act⁴ was rendered unnecessary by the small amendment to the Prisons Act⁵. There is thus no reference to the mentally ill offender (the term the Criminal Law and Penal Methods Reform Committee, recommended should replace the archaic term, criminal mental defective) in the new Mental Health Act.

Progress was slow. On 7 November, 1973, I pointed out to the Honourable the Minister of Health that, in my opinion now that the reports of these two committees of enquiry had appeared, a working party should be set up to consider and draft a new Mental Health Act. I said that it was imperative for me to be a member of the working party, and that the Crown Prosecutor, Mr. K.P. Duggan, had also intimated that he would like to be involved. On 10 October, 1974, I again wrote to the Minister of Health suggesting that the Committee include a psychiatrist, nominated by the South Australian Branch of the Australian and New Zealand College of Psychiatrists, and a selected representative from the South Australian Council of Civil Liberties. By January, 1975, a Committee to review and make recommendations on the need to rewrite the Mental Health Act 1935-1969 had been formed. It consisted of Mr. K.P. Duggan, Crown Prosecutor, Mr. C.K. Stuart, S.S.M., Local and District Criminal Court, Adelaide, Dr. J.D. Litt, Psychiatrist in Private Practice (nominated by the Australian and New Zealand College of Psychiatrists), Dr. J.H. Court, Department of Psychology, The Flinders University (nominated by the South Australian Branch of

the Australian Psychological Society), Professor G.C. Duncan, Professor of Politics, The University of Adelaide, and President of the South Australian Council of Civil Liberties, and myself as Chairman. The Committee to Review and Make Recommendations on the Mental Health Act met for the first time on Monday, 10 February, 1975. The Minister of Health, the Honourable Don Banfield M.L.C., indicated that he would like to have its report by the end of June!

The following statement incorporating my own views was approved as a working document upon which the Committee could base its enquiry.

PROPOSED AMENDMENT TO THE MENTAL HEALTH ACT 1935-1969

1. Patients in the Receiving Houses and Mental Hospitals of the State of South Australia fall into several categories:

- (1) Patients who suffer from some form of mental illness for which they require treatment.
- (2) Patients who require oversight and care.
- (3) Patients who, because of disturbed and anti-social conduct, require control for their own good or in the public interest.

Category (1) includes the majority of psychiatric patients. Of those who are admitted to units of the Mental Health Services, 80% already seek treatment voluntarily. Some, because of the nature of their illness, are reluctant to have treatment. Under the present Act, such reluctant patients frequently enter hospital under certificate; but, once in hospital, make rapid progress and are then prepared to stay voluntarily. It must be remembered that many similar psychiatric patients are treated without formality in private hospitals and in the wards of general hospitals.

Category (2) comprises the intellectually retarded and the demented elderly. There is little justification for their certification to closed institutions. The geriatric and severely retarded require nursing care, supervision and rehabilitation; the moderately and mildly retarded can live at home and in hostels. Many demented old people are cared for in nursing homes. Depending on the severity of the condition, the mental hospital at present functions like the ward of a general hospital, a nursing home or a hostel.

Category (3) refers to no one medical classification of patients. The unifying feature is the conduct of the individuals concerned. The person may suffer from a psychiatric illness, be intellectually retarded, or elderly. The person may be an example of psychopathic (sociopathic) personality disorder. Such people may be committed to a mental hospital or to the Hospital for Criminal Mental Defectives. Cases of psychopathic personality most likely end up in gaol. In this category, then, the psychiatric diagnosis has no relevance. Legal requirements take precedence, and the public interest is of primary concern. Detention and control are demanded, and for this category the mental institution is looked upon more as a prison than a hospital.

Depending then on the category into which an individual patient falls, the present mental hospital may be comparable with (a) the psychiatric ward of a general hospital; (b) a nursing home; (c) a hostel; and (d) a prison.

The present agitation regarding the lack of safeguard for a patient's rights and the protection of his civil liberties arises, I believe, from the fact that, under the present Act, the patient may be involuntarily certified to a mental hospital for a condition which falls into any of these categories.

In my opinion, there is no justification for involuntary commitment just because a patient shows signs of mental illness. People may refuse treatment for physical illnesses; psychiatric patients should have the same privilege. Neither is there any justification for the involuntary commitment of the intellectually retarded and the demented elderly just because they need care and protection. If any legislation is required for these patients it should be in the area of community welfare.

The category of patient which will be the main bone of contention is that group who, by reason of mental illness, are considered to be a significant danger to themselves or to others. Most thinking people will accept that a person who is clearly a danger to others should be under detention and control. Yet, even here, it will be recognized that it is notoriously difficult to assess a patient's degree of dangerousness, and that psychiatrists are not particularly gifted or skilled in making this assessment. Some form of Review Tribunal to assume this responsibility appears to be an acceptable solution. Differences will arise in regard to patients who are considered only to be a danger to themselves. Here it is often argued that the mentally ill suffer discrimination. The drinking driver is a danger to himself and often to others; yet no legal powers of preventive detention apply to him. So, it is questioned, why should a mentally sick person be committed to a mental hospital against his will just because he may commit suicide? Some would argue that

individuals should have the right to commit suicide if they wish. This point of view can be contested on a number of grounds, but the following two stand out:

(a) By definition, a person suffering from a psychosis, a severe mental illness, lacks insight. Can a decision by such a person to commit suicide be considered to be a rational one, and is it not the physician's obligation to protect him from the consequence of his disease?

(b) Where does danger to self and danger to others begin? In regard to suicide, for example, it may be argued that the suicide of a young mother may inflict incalculable harm on her two year old child; or the death of a father bring undue and serious hardship on his family which would be better prevented. Again, the irrational and grandiose financial dealings of a hypomanic patient may ruin his family and cast intolerable burdens on his wife and children.

There are, thus, two other sets of "rights" to be considered, apart from the civil rights of the patient. They are: the right of the patient to be given the treatment that will alleviate the symptoms of disease; and the right of relatives and others to be protected from all the consequences of the patient's mental illness.

The rules applying to the treatment of the mentally disordered offender will need to be considered separately.

On the basis of the above considerations, I suggest that the Mental Health Act needs to be revised in the following ways:

1. The fact that a person is intellectually retarded or mentally ill should not of itself be grounds for involuntary commitment.
2. There should be some provision for the involuntary commitment of a person who is mentally ill and needs treatment but who lacks insight as a result of the mental illness and is thus reluctant to receive treatment. Such commitment should be brief and not be able to be extended beyond, say, 21 days. I suggest an initial commitment for 7 days on the certificate of one doctor which gives reasons for the diagnosis of mental illness and emphasises the need for urgent observation and necessary treatment. Any extension of the first schedule, for no longer than 14 days, should be on the recommendation of a registered specialist in psychiatry. I believe the majority of suicidal patients suffering from a psychosis will be adequately covered by this provision.

An important change in the Mental Health Act will be that such a certificate would ensure the admission of a patient to any hospital with the facilities to treat a psychiatric patient.

3. Those patients who are considered to be a danger to others could be committed on the provision of certificates by two separate medical practitioners, one of whom could be specified as a registered specialist in psychiatry. The schedule should state specifically that the patient is mentally ill and a substantial danger to others. Admission would be to a closed section of a mental hospital proclaimed under the Act. As suggested by Mr. Timothy George, such a procedure could be protected against abuse by what is called "non-protested admission" whereby after a person is certified he is notified of his right to be heard, if he so desires Regular review of such patients should be provided for; and progressive opportunities for appeal against detention possibly going as far as to a judge and jury.

4. With regard to criminal patients, I consider that Sections 46-51 of the Mental Health Act should be repealed as with the transfer of patients to the Security Hospital Northfield and an amendment to the Prisons Act, such provisions are unnecessary. Though not part of the Mental Health Act, I believe Section 77a of the Criminal Law Consolidation Act should be repealed and extensive amendments of Sections 292 and 293 undertaken. The right of appeal against acquittal on the grounds of insanity should be included.

5. Except in an emergency (which may or may not need to be defined) a patient should have the right to refuse treatment that is prescribed, and consideration will need given to the desirability of including provision for this protection within the Act, or in the preamble to the Act. Similarly, it may be desirable to spell out the principles behind the legislation in the preamble - namely, involuntary commitment only for treatment or for the safety of others, with complete safeguards against compulsory treatment and improper detention.

6. The Public Trustee⁶ has requested that he be consulted over amendments to those sections concerned with the administration of the estates and personal affairs of certain patients. I would agree, and will recommend that provision be made for outpatients and day patients, as well as inpatients, to have their affairs placed in the hands of the Public Trustee.

(ii)

Before reporting upon the discussions of the Committee, I should refer to three reports, two of which have already been mentioned, which had a bearing on the final form of the proposed new Act. The Commonwealth Government produced "A Report on Hospitals in Australia" in 1974,⁷ which recommended that there should be a decentralization of mental health residential facilities and that acute and rehabilitation units should be developed adjacent to, or as an integral part of general hospitals. It could be seen that the financial power of the Commonwealth was to be used to encourage the provision of community orientated as against institution based services, and to discourage the persistence, let alone the growth, of the mental hospital system.⁸

A similar thrust towards the integration of the mental health services more closely with the other health services in hospitals and community health centres was recommended by the Committee of Enquiry into Health Services in South Australia, which was appointed by the Governor in October, 1970, and made its report in January, 1973.² The establishment of the South Australian Health Commission was a direct consequence of this report. The objects of the South Australian Health Commission Act, 1975-1976, were, among others, "to achieve the rationalization and co-ordination of health services in this State to ensure the provision of health services for the benefit of the people of the State upon principles that allow for - (a) the establishment or continuation of hospitals and health centres under the administration of autonomous governing bodies; (b) the integration of mental health services within a unified system of health care."

This report, therefore, flagged the eventual disappearance of the separate mental hospital system and the incorporation of the mental hospitals, like the general hospitals, as autonomous units with their own boards of management.

The Criminal Law and Penal Methods Reform Committee considered relevant sections of the Mental Health Act and the Criminal Law Consolidation Act in detail and commented on Part III, Division II of the Mental Health Act, those sections already referred to and soundly criticised by Timothy George. Fortunately, as already mentioned, the amendment to the Prisons Act made consideration of this area of legislation unnecessary. A very acceptable recommendation was that which substituted the term "mentally ill offender" for the archaic term "criminal mental defective". Recommended changes to the Criminal Law Consolidation Act fell outside the scope of my Committee.

At its first meeting on 10 February, 1975, the Mental Health Act Review Committee considered the extent to which it could accept or seek submissions in view of the short time given by the Minister for it to make its report. It was agreed that members should consult with the bodies they represented and that submissions should be sought from the South Australian Association for Mental Health, the Citizens Commission on Human Rights, the Consultative Council on Mental Retardation, The Law Society, the Police and the Royal Australian College of General Practitioners. Professor Duncan stated that he intended to write comments on my basic document (presented in full above) and the other members were invited to do the same.

Over the next few meetings, discussion centred around the ideas on involuntary admission that were contained in paragraphs one to three of my paper. Reports were also received that the Division of Clinical Psychologists, Australian Psychological Society, and the South Australian Branch of the Royal Australian and New Zealand College of Psychiatrists were considering the matter.

At the meeting on 14 April, a submission from the Consultative Council on Mental Retardation was received. I drew attention to two resolutions passed at a meeting of the Australian Labour Party State Council held four days earlier, relating to "the ease with which potentially dangerous patients can leave our mental hospitals and request that better supervision be provided to protect the community". These resolutions illustrated the type of social dilemma the Committee faced. On the one hand, those concerned with civil liberties wanted it to be harder for a person to be committed involuntarily to a mental hospital;

on the other, people such as those in the Labour Parry wanted to make it harder for some of those committed to be discharged.

Dr. Court and Professor Duncan presented notes for discussion. In his, Dr. Court summarised the principles he thought should be implemented in relation to involuntary admission. The suggested principles were:

1. The medical profession should have the right to detain persons deemed mentally ill and requiring urgent treatment in the psychiatric ward of any appropriately equipped general hospital.
2. Certification by any medical practitioner should be for an initial period of 72 hours, and following admission the patient must be seen by a qualified psychiatrist within 24 hours.
3. The psychiatric unit should have the power to refuse admission if the receiving doctor could show no good reason why the patient should be admitted or if the person was considered not treatable in that unit.
4. All such units should provide for patients and relatives a clear printed statement describing the facilities and provisions of the ward. Included in this, a clear statement of the patient's legal rights in relation to hospitalisation.
5. A 72 hour order may be extended by 21 days, provided this extension is authorised by a psychiatrist other than the one responsible for the initial order. (Is this practicable in a small country hospital?).
6. Throughout this period emergency treatment should be provided in accordance with medical requirements and in the patient's interests, if possible but not necessarily with the consent of the patient and/or relatives. Such treatment would exclude irreversible procedures.
7. Throughout the period of involuntary admission the patient should have the right of appeal in relation to treatment and detention.
8. Appeal should be to an independent tribunal, including a member of the legal profession, a member of the medical profession (but not of the hospital staff) and one other reputable member of the community.
9. In the event that a patient proves unmanageable in the psychiatric unit, or in any case after 21 days (amended to $3 + 21 = 24$ days), a patient will be transferred to another hospital recommended

as appropriate for extended care. (It was agreed, at a subsequent meeting, that such transfer should occur only on the certificate of two doctors, one of whom should be a psychiatrist.)

10. The criteria to be applied in relation to involuntary admission are those to be found in the Scottish Mental Health Act, namely 'any mental disorder that requires or is susceptible to medical treatment...[and] where the mental disorder....is a mental illness other than a persistent disorder which is manifested only by abnormally aggressive or seriously irresponsible conduct'.

11. The onus of proof that a person is in need of involuntary admission should lie initially with the person seeking to initiate hospitalisation and is discharged by the opinion of a medical practitioner.

Professor Duncan, while accepting the need for enforced hospitalisation in certain circumstances, indicated a persisting worry, namely, that a moral failing or deviation might be interpreted as evidence of mental illness. Although certain kinds of belief or behaviour may constitute a medical condition, or be pretty clear evidence of a medical condition, he argued that we must be extremely careful to avoid sliding one into the other. While he admitted he was not talking about acute and florid psychosis, his view was that we must bend over backwards to avoid wrongful committal and the wrongful imposition of certain kinds of treatment. He suggested that we should distinguish between those determined on suicide, those who are significant dangers or threats to others, and those who are simply incompetent or deeply confused. Duncan wrote "I would draw a (liberal) distinction between danger to others and danger to oneself - this, I imagine, will be one of the main general issues dividing us". It did, indeed, prove to be so, for Professor Duncan had strong views on a person's right to die, to commit suicide.

Dr John Litt also brought to the attention of members of the Committee a point raised at a meeting of the South Australian Branch of the Royal Australian and New Zealand College of Psychiatrists. This was the question whether the medical profession should have a legal power to treat people involuntarily out of hospital; for example, the chronic schizophrenic who relapsed when he did not take his medication. Was there a case to be made out for putting such people on probation, as it were, and bringing them into hospital for their medication if they refused to take it?

By the end of May, submissions had been received from the Consultative Council on Mental Retardation, the South Australian Faculty of the Royal Australian College of General Practitioners, and the Police Department. I reported that I had had a telephone discussion with Mr. Croft, Public Trustee, in regard to possible amendments to the pertinent sections of the Mental Health Act.

At the meeting on 26 May, consideration was given to the special problems associated with legislation for the mentally retarded as compared with that for the mentally ill. The Consultative Council had felt strongly that the mentally retarded should not be included with the mentally ill in a mental health act, and pushed for a separate act. However, my committee concluded that there was no strong reason why the intellectually handicapped should not be included under the new Mental Health Act in a separate and autonomous section. Certainly, there was a need for provisions for custodianship and guardianship of both child and adult, and it was agreed that questions of custodianship and guardianship would be better determined by a small tribunal or board. As will be seen later, this proved to be an important decision.

Two important points that arose out of the submissions made by the Police Department and the Royal Australian College of General Practitioners were considered on 6 June. The first was on the necessity for making provision for trial leave. I personally was not in favour as I believed that, with modern treatment, the majority of patients detained on a medical certificate would make improvement within the 24 days suggested and so stay on voluntarily. I believed that if a patient were well enough to have trial leave they were well enough to be no longer on certificate. I was persuaded, however, that some such provision would need to be retained for certain, long-term cases. There was less agreement with the second point made by the College that, though it would be uncommon that a voluntary patient would need to be detained involuntarily, some provision would need to be made for this in any new Act. I, for one, expressed concern that such a provision could generate apprehension in sections of the public that agreement to enter a psychiatric hospital voluntarily would expose the person to the risk of being subsequently detained against the will.

At this meeting, I suggested that I send a draft report to members in the next few days embodying my assessment of the points that had been agreed upon by the Committee to date. Members could then

distribute their own comments, corrections and amendments. A discussion of the resulting reports would then be the main item on the agenda for the next meeting. This meeting, on 14 July, 1975, concerned itself solely with the draft report I had sent to members and the comments I had received. As a result of detailed discussion, a consensus was reached on the report to be sent to the Minister of Health. This was to be entitled "First Report" as, if the Minister accepted the recommendations of the Committee, more work would have to be done and a further report or reports made.

In this first report dated 16 July, the first five paragraphs were adopted from my original discussion paper. There followed a short review of the trends then current in the planning of health services and the implications of these for the future of the Mental Health Services. I then pointed out that the Mental Health Act Review Committee had met on eleven occasions and, as a result of its review of the Mental Health Act 1935-1969, it had reached the conclusion that amendment of the existing Act would be quite ⁱ unsatisfactory and that an entirely new Act was required to meet the changed conditions. It made a number of important recommendations. The first was that the provisions for the acutely mentally ill should be different from those for the chronically mentally ill, the mentally retarded and the demented. The first group were seen as medical problems; the second group more usually constituted problems for society. The second argued that, because the chronic psychotic, the more severely intellectually handicapped and the demented elderly all presented similar problems, they should be grouped together under the term "mentally handicapped". This was a new idea. Another new idea was that the question of guardianship and/or custodianship of persons in the latter group should be determined by a small tribunal or board. Last, the Committee suggested that a discussion paper, setting out the provisions of the proposed Act, be prepared and that a seminar be held with representatives of all groups which had been asked to make submissions. The final document that would emerge from the deliberations of the seminar would provide the basis for the Bill to be presented to Parliament.

At the meetings on 29 September and 6 October, consideration was given to the role of the Public Trustee, the management of the mentally abnormal offender, the proposed powers of the Police, the ability to grant trial leave, and the provisions for guardianship/custodianship. Copies of the proposed amendments to the New South Wales Mental Health Act in regard to safeguards against the compulsory

treatment of involuntary patients, particularly in relation to psychosurgery, were distributed. There was some discussion as to whether safeguards against psychosurgery should be incorporated in this report of the Committee, and it was unanimously agreed that, because of the sensitive and controversial nature of this issue, it would be better not to mention this treatment specifically in the report. The Minister had agreed that a seminar be held on 29 November, 1975, where any concerns could be raised and discussed openly by all present.

On 16 October, 1975, I submitted the Second Report¹⁰ to the Honourable the Minister of Health, with the request that it be printed, and informed him that two representatives from the following organisations had been invited to attend the Seminar:

Citizens Commission on Human Rights
 South Australian Council for Civil Liberties
 Australian and New Zealand College of Psychiatrists
 Australian Psychological Society
 South Australian Association for Mental Health
 Consultative Council on Mental Retardation
 Law Society of South Australia
 Police Department
 Royal Australian College of General Practitioners
 Public Trustee
 Australian Association of Social Workers
 Parliamentary Liberal Party of Australia
 Parliamentary Liberal Movement
 Parliamentary Australian Labour Party
 Recovery Grow

The Minister approved and the Report was printed for distribution. At its meeting on 3 November, the Committee decided upon an agenda and approved the domestic arrangements I had made for

secretarial help and lunch. Finally, the Committee agreed that a meeting be held on 8 December to consider the Final Report which would hopefully emerge from the discussions.

(iii)

The Seminar was held as planned. My opening remarks summarised the arguments in favour of the writing of an entirely new Act, the considerations that led to the recommendation that it be in two parts, and a brief outline of the criteria considered to be necessary for involuntary commitment.¹¹ The debate was lively and constructive. Apart from some extreme views put forward by the Scientologists (Citizens Commission on Human Rights) which were largely not acceptable to the remainder of the participants, the concept of the proposed legislation was supported.

A number of submissions were made. Of these, I shall refer to only two at this time, as I believe they had a significant influence on the content of the report. Professor Graeme Duncan, Council of Civil Liberties, was concerned with the danger of wrongful and unnecessary detention. He agreed that this could be met in part by the multiplication of review and appeal procedures. Also, the provisions defining the circumstances or cases warranting detention could limit forcible commitment to persons who are mentally ill and a manifest and substantial danger to others,, and exclude those who behave differently or "immorally", or who harm only themselves (an extremely difficult issue), or who may benefit from treatment but do not want it. He went on:

"If we assume, as I do, that at some time some persons may be required to submit to forced hospitalisation (or confinement or detention), we need to be very clear about, not only what constitutes or counts as mental illness, but also which categories of mentally ill persons, or the circumstances under which mentally ill persons, might be committed involuntarily. Certain of the criteria of committal seem more appropriate than others, and [I] find harm to others a far more convincing reason for detention than harm to oneself. In my view, involuntary admission is justified only where the person suffers from a severe mental illness, or a physical illness with severe mental

effects **and** constitutes a clear and significant social threat or hazard **and** can be treated within the institution to which he or she is committed."

The other helpful information I provided myself. This was a photocopy of the relevant sections of the Tasmanian and Queensland Mental Health Acts regarding Mental Health Review Tribunals. Though these had different functions in each State, they were both constituted in the same manner: one member was to be a legal practitioner, one was to be a medical practitioner and one was to be neither a legal nor a medical practitioner. The Citizen's Commission on Human Rights suggested that the Mental Health Review Tribunal be composed of a lawyer, a medical doctor, but not a psychiatrist, and a member of a human rights group. Odd though it may appear to some, I supported this proposition.

It was my view that the Tribunal would essentially have two roles: to conduct regular reviews and to hear appeals. Where a medical practitioner initiated the detention of a patient in an approved hospital or where a protected person was placed in the custody of another person by order of the Guardianship Board, such actions had to be seen to be the most appropriate actions. Thus, if an action leading to detention or custody extended beyond a period of two months, provision was made for automatic review. An appeal could be instituted after the expiration of three days from the day on which a person was admitted to an approved hospital, or once an order had been made by the Guardianship Board. It was my view, too, that, when the Mental Health Tribunal reviewed orders made for the detention or custody of a patient, it would be concerned only with the question of detention or custody. Similarly, when the Tribunal considered appeals, it would not be concerned with the diagnosis of the mental condition but whether, on the evidence available, the condition required that the patient should continue to be detained or whether the order of the Guardianship Board should still be carried out.

In my view, the Tribunal would have to consider not only the human rights of the patient but also those of the people who could be subjected to stress and harassment if the patient were discharged from commitment. In such circumstances, the psychiatric diagnosis was less relevant than the history of the person's behaviour. For these reasons, rightly or wrongly, I believed that a general practitioner would have a better view of the possible social pressures on the family and the community than a psychiatrist.

The final meeting of the Mental Health Act Review Committee, held on 8 December, 1975, was concerned with a review of the report I prepared as a result of the successful Seminar. A number of changes were agreed upon. The Final Report¹² differed from the Second Report in a number of significant ways. The basic concept that the Act be in two parts was accepted. Possibly the most significant change was the introduction of a preamble to the report itself. Here, eight objectives set out, as it were, the philosophical context in which the Act should be accepted and administered by the Health Commission and the Government.

Many of the changes demonstrated the value of the free and open discussion at the Seminar. It was pointed out that, though the requirement that a person admitted to a hospital as an emergency on the recommendation of a medical practitioner must be examined by a registered psychiatrist within 24 hours was quite proper, it may not always be possible outside the metropolitan area. The words "where possible" were therefore inserted.

It was agreed that the requirement that a multi-lingual statement regarding a patient's legal rights should be provided for patients and relatives referred only to those admitted involuntarily. It was important that such a statement should be given to the patient and a relative on admission.

The requirement that consent be obtained before any treatment was given was strengthened, though the right of the patient to be provided with treatment in an emergency in accordance with medical dictates and in the patient's interests was retained.

The provisions made for review and appeal procedures were also strengthened. It was made clear that, at any appeal to a review tribunal, the patient should have the right to legal counsel at no cost, and that any subsequent appeal to a Court presided over by a Judge should also be at no cost. Legal aid should be freely available. However, the provision was retained that, if an appeal were lodged by a relative or some other person or persons and the Judge considered the basis of the appeal to have been frivolous, costs could be ordered against that person or persons. Nevertheless, the rights of those caring for the

patient were also recognized. It was recommended that provision be made for protection from liability of any person in respect of an act done in good faith in pursuance of the Act.

The representatives of the Police Department were particularly helpful, in pointing out the problems they could foresee if the police were to co-operate fully in the implementation of the Act. For example, there was no provision, in a serious and urgent situation, for Police to break and enter into premises and apprehend and remove a person, suspected of being mentally ill and in need of treatment. Reference would also need to be made to ensure that the costs of medical or psychiatric examinations, for conveyance, and the transportation of patients, were covered, and also that compensation for the Police or other persons, acting in pursuance of the Act, would be assured against any damage or injury caused by mentally ill patients.

There were provisions for the financial management of a mentally ill person's estate, for the licensing of psychiatric rehabilitation hostels, and for a penalty clause for improper conduct.

In the second part, the provisions in regard to the Guardianship Board were greatly expanded. The legal practitioner was elevated to the status of magistrate. The possible range of options available to the Board were spelled out. The Board could make orders for the financial management of a mentally handicapped person's affairs; assume responsibility for certain important life decisions, and delegate certain of its caring responsibilities. It had the ability to issue a detention order requiring a patient to undertake treatment, shown to be beneficial to his mental health, either from a private general practitioner, a private psychiatrist, a psychiatric outpatient department of an incorporated hospital, or to be admitted to the psychiatric unit of an incorporated hospital or to an approved private psychiatric hospital. If the patient refused to co-operate with the order, it had the power to order his involuntary admission to a hospital for the necessary treatment, or even to be detained in a maximum care hospital for protection and treatment, as the Board saw fit on the evidence before it. Naturally, the rights of the person or his relatives to have the Guardianship Board review its decision, or to appeal against the decision to a Court presided over by a Judge, at no cost to the mentally handicapped person, were clarified. This "constructive coercion" programme was seen as a way to deal with one of the most worrying social problems associated with the

chronically ill psychotic person: namely, the disturbed behaviour which reappears, to the stress and harassment of those about him, when the patient fails, or refuses, to attend for the regular drug treatment that keeps the disturbed behaviour under control.

As in the first part, details of the role of the Police in regard to the care and protection of a mentally handicapped person were included in this part.

On 17 December, 1975, I submitted this Final Report to the Honourable the Minister of Health with the recommendation that a new Act be framed to replace the existing Mental Health Act 1935-1974 and that the proposed Act be in two parts:

- (1) The treatment and protection of the mentally ill; and
- (2) The care and treatment of the mentally handicapped.

My recommendation was accepted.

THE SEMINAR.

Those who attended on Saturday, 29 November, 1975, at the Nurses Memorial Centre, 18 Dequetteville Terrace, Kent Town.

Dr. W.A. Dibden Chairman	Director of Mental Health Services.
Dr. J. Court Prof. D.G. Duncan Mr. E.P. Duggan Dr. J.D. Litt Mr. K.C. Stuart	Mental Health Act Review Committee.
Ms. L. Gazzard Ms. I. Bull	Australian Association of Social Workers.
Mr. D. Pritchard Dr. Ross Harris	Australian Psychological Society.
Mr. P. Bowen Mr. B. Wilson	Citizens' Commission on Human Rights.
Mr. G. Sharman Mr. D. Crawford	Consultative Council on Mental Retardation.
Mr. C. Warwick Mr. B. Maddison	GROW
Mr. P.J. Norman Mr. I.D. Norsworthy	Law Society.
Hon. Ann Levy	Parliamentary Labor Party.
Hon. C.M. Hill	Parliamentary Liberal Party.
Hon. J. Carnie	Parliamentary Liberal Movement.
Chief Supt. L. Brown Chief Supt. T. Howie	Police Department.
Mr. E.G. Croft Mr. E.G. Wilkins	Public Trustee.
Dr. R.S. Gillen Dr. C. Radeski	Royal Australian and New Zealand College of Psychiatrists.
Dr. R. Brummitt Dr. J. Allan	Royal College of General Practitioners.
Mr. Bob Smith Mr. Brian Smith	S.A. Association for Mental Health.
Ms. J. Worrall Mr. K.E. Klæbe	S.A. Council of Civil Liberties.

CHAPTER 12

THE BILL

It was the work of the Parliamentary Counsel to prepare a Bill for presentation to Parliament. I had never assisted in this before. I sent a copy of the Final Report¹ of the Committee appointed to review and make recommendations in regard to the Mental Health Act 1935-1974 to act as their guide-line.

The first draft² was prepared by 2 July, 1976. It was a disaster. My reaction was expressed in notes that I made on 5 July. I wrote:

'The proposed Bill does not seem to recognize the philosophy underlying the Final Report of the Committee. This clearly separated the provisions for the treatment of the acutely mentally ill from the care and protection of the mentally handicapped. The indication that this philosophy has been lost is in the condensation of the two separate concepts in the opening paragraph which reads: "An Act to make provision for the care and protection of persons who are mentally ill or mentally handicapped". The present structure of the Act also ensures that the Mental Health Services are kept separate and not integrated as desired into an overall Health Service. It does not stress enough the rights of people to informal admission for treatment and care."

The way in which the proposed Act was arranged seemed to indicate that the Parliamentary Counsel had found great difficulty in divorcing their collective mind from the archaic stereotypes of the existing Mental Health Act. Perhaps I did not realize how the Parliamentary Counsel worked.

The old idea of Reception Centres was obnoxious. It destroyed the concept of patients being able to be admitted to any hospital with the facilities to treat them. So was the Division titled "Apprehension of Persons who appear to be suffering from Mental Illness or who are Unlawfully at Large". Nothing could better sustain the old fear of "certification" than this echo from the existing Act. But, even more so, my conviction that the philosophy behind the involuntary commitment of acutely mentally ill persons was not understood was demonstrated by the way in which the criteria that justified involuntary admission had been dealt with. In the Final Report the three criteria were listed as follows:

1. The patient shall be suffering from a mental illness that requires treatment; and
 2. Such treatment can be obtained only as a result of admission to and detention in a hospital;
- and
3. The interests of the health and safety of the patient or the protection of other persons cannot be secured otherwise than by such admission and detention. These were contracted to:-

"Where a legally qualified medical practitioner is satisfied -

- (a) that a person is suffering from a mental illness that requires treatment; and
- (b) that that person should be admitted as a patient into a reception centre in the interests of his own health and safety or for the protection of other persons, the medical practitioner may make an order for the admission of that person into a reception centre."

I stated that it was imperative that the three points made in the Report be included in the Bill unchanged.

Though there were other sections to which I objected, I found it interesting the way they had, in general, dealt with the Report. The Report had concentrated on the patient, his illness, his relatives and those about him; the proposed Bill laid emphasis on the organization and administrative structure. The Report had recommended that the proposed Act be in two parts: one dealing with those cases which were clearly medical; the other where the problem was essentially social. Instead, the Parliamentary Counsel dealt first with medical admissions and then defined the constitution, the powers and the functions of the

Guardianship Board and the Mental Health Review Tribunal. I did not find this method objectionable; it was rather neat and I could see the rationale for it.

One of the first battles I won against the Parliamentary Counsel was to secure the inclusion of the Objectives, albeit in abbreviated form, that the Commission should seek to attain. It had been argued that there was no point in including such objectives in an Act of Parliament because they could not be sustained at law. But, I managed to uphold the point that it was important for the Government to be seen to accept the principles behind the Act and the need to provide the facilities that were basic for its proper implementation.

Though Part IV of the proposed Bill satisfactorily established the Guardianship Board and its procedure, it failed to confer upon the Board the range of options open to it which had been set out in some detail in the Report. The sections seemed to be concerned only with the administration of estates.

Similarly, Part V adequately established the Mental Health Review Tribunal. It was interesting that, in determining the membership of the Tribunal, the Counsel interpreted "a member of the medical profession" as a "registered psychiatrist". The Committee had had in mind a general medical practitioner; a psychiatrist was not preferred. We had argued that the Tribunal, in reviewing the continuing detention of a patient or hearing appeals in relation to detention and treatment, would be concerning itself more with the behaviour of the patient and whether his discharge would present a danger to others or cause stress and harassment in the community, rather than with a psychiatric diagnosis. We felt that a general practitioner would be as competent as, if not more competent than, a psychiatrist in assisting the Tribunal to reach a decision on this point. My argument did prevail. Subsequently, however, there has been considerable debate in favour of the interpretation originally made by the Parliamentary Counsel.

One glaring omission in this first draft, that I had to point out, was that many sections in the Report, which had been requested by the Police Department at the Seminar and inserted in the Final Report, had been completely ignored.

The second draft prepared by the Parliamentary Counsel was completed on 15 July, 1976. The way the Act was arranged was a distinct improvement. Part III now referred to "Admission of Persons suffering from Mental Illness" and not to "Reception of Patients". The bases on which patients could be admitted and detained pursuant to an order by a medical practitioner were now as in the Final Report. "Approved Hospitals" had taken the place of "Reception Centres". Another improvement was the insertion of a footnote beneath a new, special provision for the Guardianship Board, which explained why it had been inserted. However, I was still concerned that not all the safeguards set out in the Report had been written into the proposed Bill.

Dr John Litt, a member of the Mental Health Act Review Committee, and I strongly objected to the new Part IV Division IV. Section 32. (1) in this Division stated that, where a patient is detained in 411 approved hospital, he shall not be subjected to (a) brain surgery, or (b) any form of electro-convulsive therapy, during the first three days of his detention in that hospital; and (2) any person who acts in contravention of subsection (1) shall be guilty of a misdemeanour. Section 33. (1) stated that a person suffering from a mental illness admitted into an approved hospital (whether as a voluntary patient or by order under this Act) shall not at any time during the period of hospitalization be given any form of psychiatric treatment unless - (a) two registered psychiatrists have authorized that treatment; and (b) the consent of the person and a relative of that person (if any) has been first obtained. Subsection (2) warned that a person who acts in contravention of subsection (1) shall be guilty of a misdemeanour.

Now, admittedly, a footnote had been inserted which read that "the provisions of the Division are put in the Bill in their present form for the purposes of discussion". This was fine. My concern was that the provisions as written were promoting the same type of propaganda to engender distrust in psychiatrists that the Scientologists, as the Citizens Commission on Human Rights, had attempted to do at the Seminar and in their publications.

In a report to the Mental Health Act Review Committee, the Citizen's Commission on Human Rights - Psychiatric Violations, among 23 "motions of amendment" to the discussion paper presented to the Seminar, had proposed the following:-

Motion 8: (a) "All treatment shall be given only with the person's informed consent, or if, by reason of unconsciousness, he is unable to give such consent, his legal adviser. Penalty for failure to comply with this section should not exceed \$50,000."

(b) "All known or potential side effects of a proposed treatment, drug, technique etc., are disclosed in laymen's terms and in writing to the patient or his legal adviser, who shall sign a written agreement to undergo precisely specified treatment. The wishes of the person undergoing the treatment shall at all times be the decisive factor in administering, or not, treatment."

(c) "That the penalty for failure to comply with this section should not exceed \$50,000 or a 1-year gaol sentence."

The reasons for Dr. Litt's and my finding the proposed Division IV unacceptable was that, as with the Scientologists, the Parliamentary Counsel were showing a blatant ignorance of the true nature of psychotic illness, and a desire to place rigid constraints upon psychiatrists that were not imposed on other members of the medical profession. One proposal was just plain silly: no psychiatrist of repute, let alone those working in the suggested Approved Hospitals, which would include the University Departments of Psychiatry, would even consider brain surgery during the first three days of detention in a hospital; neither would he be qualified to carry out the surgery. The other proposal found to be particularly offensive was that which sought to prevent any form of psychiatric treatment from being given to a person suffering from mental illness, admitted to an approved hospital, unless it were authorized by two registered psychiatrists. The - provision was ludicrous, as well as being offensive, because it did not preclude treatment, such as psychotropic drug therapy or psychotherapy, from being administered to patients outside approved hospitals by persons unqualified to do so. Finally, the provision for the severe punishment of a qualified specialist in psychiatry, for failing to comply with such constraints, was unique and had to be rejected. The concept of informed consent was readily accepted. But, I could not accept that the wishes of the patient should be the decisive factor in all circumstances; for that would deny the existence of psychotic illness, prevent a delusional, mentally disordered patient from being given appropriate treatment, if necessary against his will, and make the whole concept of a mental health act irrelevant.

The third draft was ready by 4 August, 1976. The Director of Mental Health Services was defined and given the general administration of the Act. Part III, Division III, which had read - "Apprehension of Persons who Appear to be Suffering from Mental Illness or who are Unlawfully at Large" was contracted to "Apprehension of Persons who Appear to be Suffering from Mental Illness".

Unfortunately, my concern regarding the bias of Parliamentary Counsel was not lessened when I read the proposed definition of "psychiatric treatment" and considered it in relation to Part III, Division IV - "Treatment of Patients in Approved Hospitals".

"Psychiatric Treatment" was said to mean: (a) psycho-surgery, (b) electro-convulsive therapy; (c) psychotropic drug therapy; and any other prescribed treatment.

Division IV read:-

20. (i) Subject to this section, a person shall not administer psychiatric treatment to a patient in an approved hospital -(a) unless -
- (i) in the case of psychosurgery or convulsive therapy - the treatment has been authorized by two psychiatrists (at least one of whom is a senior psychiatrist)
 - (ii) in any other case - the treatment has been authorized by a psychiatrist;
- and
- (b) unless the consent in writing
 - (i) where the patient has sufficient command of his mental faculties to make a rational judgment in the matter - of the patient; or
 - (ii) in any other case - of a guardian or relative of the patient, has been obtained.
- (2) A person is not obliged to observe a requirement of sub-section (1) of this section where -
- (a) the nature of a mental illness from which the patient is suffering is such that treatment is urgently needed to protect the patient or some other person from injury; and
 - (b) compliance with the requirement is not practicable in the circumstances.

Understandably, in my opinion, I took great exception to this part of the proposed Bill. I pointed out that, though I would agree to the opinion of two psychiatrists being sought before psychosurgery (a rare procedure by this time), the opinion of only one psychiatrist, the one in charge of the treatment of the patient, was sufficient for electro-convulsive therapy. But I could not abide the arrogant assumption that, in an approved hospital, the prescription of psychotropic drugs had to be authorized by a psychiatrist. It would be in the approved hospitals that medical practitioners would be under training as psychiatric specialists, their training being supervised by registered psychiatrists. The proposal imposed constraints in these places of excellence, while psychiatrically untrained general practitioners and physicians, outside the approved hospitals, would be free to prescribe the same psychotropic drugs to their patients at will.

An improvement in this third draft was the clarification of the persons who could initiate appeals in respect of the detention of patients in approved hospitals; and, similarly, with appeals against orders of the Guardianship Board.

My problem with the Parliamentary Counsel was demonstrated in the next draft of 10 August, 1976. Though the definition of "psychiatric treatment" was removed, the Division IV - "Treatment of Patients in Approved Hospitals", was made even more restrictive. What I found so irksome was that these people with a legal training arrogantly assumed the right to push for the inclusion of their own ideas and to ignore the recommendations of a highly trained and expert committee, that had worked for months to produce a report, which had then been considered at a day-long seminar and supported by the representatives of bodies intimately concerned with the subject. Not only had Division IV - Treatment of Patients in Approved Hospitals - been repeated unaltered, but new sections (3) and (4) had been added:-

(3) This section applies to the following forms of psychiatric treatment:-

- (a) psychosurgery,
- (b) treatment involving the administration of a restricted drug;
- (c) electro-convulsive therapy; and
- (d) any treatment prescribed by regulations.

(4) In this section "restricted drug" means -

- (a) lysergic acid diethylamide;

- (b)
- (c) or
- (d) any other drug prescribed by regulations.

A footnote stated: "Space has been left above for the names of any other drug that ought to fall into this category".

To me, these uncalled-for inclusions said it all. The Scientologists had screamed in their publications that psychiatrists were not to be trusted; the Parliamentary Counsel was saying the same thing. The proscriptions that they suggested should be written into the Bill implied the same distrust and were just as offensive. They were to apply to all patients whether admitted informally or involuntarily to Approved Hospitals. Voluntary patients were to be denied the right to determine their treatment in consultation with their psychiatrist. Patients in Approved Hospitals were to be discriminated against by comparison with those in other hospitals. Psychiatrists were to be treated differently from other members of the medical profession.

I took a very positive stand. I said that psychosurgery and the type of drug referred to were not used in the treatment of acute psychiatric illness. Voluntary patients should have the same freedom of choice and rights to treatment as patients in other hospitals suffering from other diseases. The principle of informed consent had been accepted. I demanded that these sections be omitted and a new Division IV be drafted.

Notwithstanding these strong differences of opinion, the drafting was going well and the draft presented on 9 September, 1976, proved to be the last. I agreed to a cumbersome Division IV; but one that was more acceptable. It clearly defined treatment, such as psychosurgery, to which popular exception had been taken; it made no reference to drugs of any kind, but left the way open for regulation to be imposed in the future if that were seen to be necessary. This satisfied the Parliamentary Counsel.

However, the Parliamentary Counsel found it necessary to add an untidy Schedule to the draft Bill. This requirement arose because there was no mention of mentally ill offenders in the proposed new Act and it was thus necessary to carry over certain provisions from the existing Act regarding Criminal Mental

Defectives. Similarly, there were provisions in relation to the Administration of the Estates of the Mentally Ill and Mentally Handicapped that had to be extended until such time as the Act under which the Public Trustee operated could be amended. (This was, in fact, done by the Mental Health Act Amendment Act, 1979.)

It was agreed that a Bill be prepared for presentation to Parliament.

CHAPTER 13

THE ACT

As the Minister of Health, the Hon. Don Banfield, was a member of the Legislative Council, the Upper House in the South Australian Parliament, the Mental Health Bill was presented to the House of Assembly on 14 October, 1976, by the Minister of Community Welfare, The Hon. R.G. Payne. He stated that the Government intended that the Bill would proceed to a Select Committee, and received leave to have the second reading speech¹, which explained the Bill² in detail, incorporated in "Hansard" without his reading it. The adjourned debate on the second reading took place on 19 October, 1976, and received support from all speakers. The Bill was read a second time and referred to a Select Committee of seven members, consisting of Messrs. Becker, Langley, McRae, Millhouse, Payne, Wells and Wotton.. The committee had power to send for persons, papers and records and to adjourn from place to place. It was to report by 23 November.

As the Select Committee had not completed its inquiry on the day for report, two further orders of the House extended the time for reporting to 29 March, 1977. The Committee held 21 meetings and heard evidence from 32 witnesses. A further 16 persons and organisations submitted written evidence. An opportunity was given to all persons who wished to give evidence before the Committee to do so. The Committee also accepted an invitation from the Superintendent to inspect Glenside Hospital. A full and frank discussion took place with senior staff during which the deficiencies of the past, present practice and the hopes and plans for the future were covered.

The Report of the Select Committee on the Mental Health Bill, 1976,³ was signed by its Chairman, R.G. Payne, on 5 April, 1977. It was gratifying to me to note that the Committee recognised what I

considered to be the outstanding difference between the proposed legislation and the existing Act, namely that a patient would automatically be released from detention at the end of an order unless a further order were made. The proposed Act ensured, for example, that in any event at the end of a three day order the patient must be released from hospital unless a "21 day" order were made. There was, as well, always the right of appeal. Its recommendations, in my opinion, improved and strengthened the Bill. For example, it recommended the broadening of the "Objectives of the Director and the Commission" and two additional paragraphs were added. There were now nine in all. This result was particularly pleasing and rewarding for me in view of the struggle I had had with the Parliamentary Counsel to have "Objectives" included in the proposed Bill at all.

Other suggested changes clarified or amplified clauses. Where the Bill required that a patient be given a statement of their rights, etc., the Committee recommended -

"Where a patient is illiterate, or too disturbed to read and comprehend the statement referred to in this section, the superintendent shall take such steps (if any) as may be practicable in the circumstances to convey the information contained in the statement to the patient."

The role of the Police was extended by an additional subclause as follows:

"(3) Where a member of the police force apprehends a person and brings him for examination by a medical practitioner in pursuance of this section -

- (a) he shall render such assistance as may be necessary for the purposes of examination; and
- (b) where the medical practitioner makes an order for the admission and detention of the patient in an approved hospital, he shall, if the medical practitioner requests, convey, or arrange for the conveyance of, the patient to an approved hospital in accordance with the order."

The section on psychosurgery was made even more restrictive, but as the operation was performed infrequently and only at a specialist neurosurgical clinic in Sydney, New South Wales, I did not object. More importantly, the Committee supported the thrust of the proposed legislation to safeguard the civil rights of patients by inserting an additional subclause in the clause dealing with attendance before the Guardianship Board as follows:

"Before the Board makes an order, direction or requirement in relation to any person, it shall, wherever practicable, afford that person an opportunity to appear before, and make representations to, the Board."

And later, in regard to any matter involving the exercise of a power conferred in relation to a protected person, it stated that the Board shall -

"give due consideration to the expressed wishes (if any) of the protected person;" and -

"treat the welfare of the protected person as the paramount consideration".

Finally, a new clause was inserted to make clear the duty of any person, acting in the administration of the proposed Act, to maintain confidentiality. Failure to do so would constitute an indictable offence.

The amended Bill, which cited the Act as the "Mental Health Act, 1976-1977"⁴, passed through both Houses without further amendment and was assented to on 12 May, 1977. It was now time to draw up the necessary regulations. This was done, and "Regulations under the Mental Health Act, 1976-1977" were made by the Governor in Executive Council on 13 September, 1979.

Previously, on 22 February, 1979, the Governor in Council⁵ had appointed the undermentioned to be Members (for a term of three years) of the Guardianship Board:

Ian Ross Bidmeade, LL.B. (Chairman).

William Fulton Salter, M.B.,B.S., D.P.M., M.R.A.N.Z.C.P.

Oscar Dale Hassam, B.A., Dip.Soc.Sci (Psych).

Mary Prudence Rumbold, B.A., Dip.Soc.Admin.

Edgar Rowland Smith, B.Sc.(Hons), Dip.Ed., Dip.T., MA.C.E.

The Governor in Council, on the same day, appointed the undermentioned to be Members (for a term of three years) of the Mental Health Review Tribunal:

Judge Ian Brandwood Burnett, LL.B. (Chairman).

Rosemary Anne Crowley, M.B.,B.S. Keith Ronald

Darwin, B.A., Dip.Ed.

The Act was proclaimed and became law on 1 October, 1979.

EPILOGUE

THE MENTAL HEALTH SERVICES: 1979-1989

The gestation of this story has been much longer than anticipated. It had been agreed that it should end with the proclamation of the new Mental Health Act in 1979. It is now 1991, twelve years on. For completeness, I think I should continue parts of the story. The most appropriate place to start is where I left off: with the new Mental Health Act. The most appropriate point to finish, I have decided, is 1989, just fifty years from when I graduated in 1939.

By the time the new Mental Health Act was proclaimed in 1979, I had retired from the Public Service. However, the South Australian Association for Mental Health had, prior to that, accepted my invitation to prepare a booklet to explain the terms of the new Mental Health Act. A sub-committee was set up by the Association. The cost of publishing was to be born by the Department. This "Information Booklet" had a comprehensive index and lucidly set out to explain the Act in a "Question and Answer" format. Dr. John Clayer and Mr. Brian Smith from the Association for Mental Health were particularly involved in ensuring the success of this free publication which was widely distributed.

The new Mental Health Act was well received. The Hon. Mr. Justice M.D. Kirby,¹ then Chairman of the Australian Law Reform Commission, made Mental Health Law Reform the subject of the Twentieth Barton Pope Lecture which he delivered for the South Australian Association for Mental Health in Adelaide on 23 September, 1980. In this he pointed out:

"Moves to ameliorate the treatment of the mentally ill can be traced to biblical times. In recent Australian history, however, the 'first wave' of mental health law reform occurred in the late 1950's and early 1960's with the passage of Mental Health Acts in all States, which replaced 19th century lunacy laws The most important innovation was probably the facilitation of voluntary admissions to mental hospitals."

Mr Justice Kirby then discussed what he termed the 'second wave' in mental health law reform. This signified a change of approach that was represented by the "important reforms to mental health law" that commenced operation in South Australia when the Mental Health Act 1976-1977 was proclaimed in October 1979. "The Act provides a new approach to the treatment and protection of persons who are mentally ill or handicapped. It expressly provides a list of objectives which the Director of Mental Health Services and the South Australian Health Commission should 'seek to attain'..... [It] introduces detailed machinery and procedures which are designed to achieve the stated objectives."

This author considered that it is in the provision of external scrutiny of medical decisions, which will ensure that proper weight is given to the value our society traditionally puts upon liberty, including the liberty of those alleged to be mentally ill, that the new South Australian legislation made important advances, and commended the establishment of the Guardianship Board and of the Mental Health Review Tribunal. He added: "Perhaps the most innovative provision of the new South Australian Act is section 39 which provides that in every application to the Tribunal or the Supreme Court the person in respect of whom the appeal is brought shall be represented by counsel".

Mr. Justice Kirby prophesied that everyone concerned with mental health legislation would be studying the effectiveness of the operation of these legislative advances. There was considerable interest, therefore, when a report was made recently by Adams and Hafner² on the effectiveness of the Guardianship Board after over 10 years of functioning. These authors stated:

"During that time, [the Guardianship Board] has enjoyed the firm support of mental health workers and it appears to be highly valued by most of the relatives of those chronically mentally ill people whose interests it seeks to safeguard. Moreover, the benefits of the Guardianship Board appear to be recognised, at a practical level, by a majority of those patients under its protection. The proposed changes to the Board are Likely to enhance its acceptability to patients and then-relatives."

The proposed changes referred to have arisen from a review of the Guardianship Board and the Mental Health Review Tribunal initiated by the then Minister of Health, Dr. John Cornwall, and approved of by Cabinet in August, 1988³. It was pointed out in the report that was brought down in May, 1989, that the legislation under which the Board and the Tribunal were established, the Mental Health Act 1977, was pioneering and far-sighted, and that the role of multidisciplinary tribunals and the notion of guardianship were new to the mental health area. This pioneering legislation had subsequently been developed and refined by most States in Australia. Alternative models of guardianship had been developed. The Victorian legislation enacted in 1986 and based on the South Australian legislation contained, for example, a number of features which could well be adopted.

The report recommended that a new Board, a Guardianship and Administration Board, be established under independent legislation with appropriate amendments to the Mental Health Act. It argued that guardianship was a concept that was relevant and useful for a wide range of people with a disability and that the current legislation restricted access to those people with a 'mental illness' or 'mental handicap'. The review recommended that people with a disability and in need of guardianship be eligible for referral to the Board if he or she were unable to make reasonable decisions.

I personally am delighted with the recommendations, not only because the philosophy underlying the concept of the Guardianship Board, spelt out in detail in Chapter 11, has been amply vindicated but also because the problems associated with the chronically mentally ill have been finally recognised as social problems and no different from those associated with other disabilities. As a bonus, there is the probability that any newer mental health act will be one of the shortest in the world; and the mentally ill will no longer be stigmatised and discriminated against in legislation but take their place among all respectable disabilities.

If statistics count for anything, the educational programme for psychiatrists in training has been a continuing success. In 1939, Dr. H.M. Birch was the only doctor in South Australia, I believe, with a senior qualification in psychiatry, the Diploma of Psychological Medicine from the Conjoint Board of the Royal Colleges of Medicine and Surgery in England. When the Australasian Association of Psychiatrists was founded in 1946, there were seven Foundation Members from South Australia, including Drs. Birch, Ray

Binns, Harry Southwood and myself, all mentioned in this biography. A separate register of specialists was not compiled by the Medical Board of South Australia until 1975. The number of specialists in psychiatry was then sixty-five. By 1989, the number had increased to one hundred and twelve. What is more, the number of psychiatrists in sub-specialties like child and adolescent, and forensic psychiatry is significant. Now admittedly not all these would necessarily have been trained in Adelaide; but there can be no doubt that the programme stimulated teachers, encouraged postgraduate students and achieved results.

There are now excellent research programmes in the Departments of Psychiatry at the Adelaide and Flinders Universities, at the Dibden Psychiatric Research Unit and the Mental Health Research and Evaluation Centre at Glenside Hospital. There is a Chair in Child Psychiatry in the Department of Psychiatry of the University of Adelaide, under the leadership of Professor Robert Kosky, based at the Adelaide Children's Hospital. A Chair of Rehabilitation Psychiatry, now occupied by Professor A.C. McFarlane, was inaugurated by Hillcrest Hospital to celebrate its Diamond Jubilee Year in 1989.

The Mental Health Services, over the past fifty years, have slowly become more efficient. On 31 December, 1939, the number of inmates at Parkside Mental Hospital was 1313 and at Northfield Mental Hospital and Enfield Receiving House 547. By 1989, the number of available beds at Glenside Hospital had been reduced to 439 and at Hillcrest Hospital to 303. (Enfield Hospital had been closed in 1982.) Of course, this great improvement so far as the patients are concerned has been achieved by greatly expanded community services, by increasing community support for the mentally ill and by developing non-hospital alternatives of care. By improving their training and expertise, clinical staff were able to assess and treat patients without having to resort to the relatively easier, but disruptive and often stigmatising alternative of admission to hospital.

In retrospect, there is a sense of achievement in what was accomplished during my period as Director of Mental Health Services. There are, however, two disappointments. I had been particularly pleased with the administrative and architectural innovations incorporated in the Security Hospital Northfield and Willis House, the inpatient, outpatient and day patient unit for adolescents situated next to Enfield Receiving House. It had been an achievement to rid Glenside Hospital of Z ward and locate the forensic unit

adjacent to the Yatala Labour Prison. The thoughts behind the placement of the Security Hospital have been told in Chapter 9. Now, after a mere fourteen years, Hillcrest Hospital in its Diamond Jubilee year⁴ proudly reported that "James Nash House, which replaced the Northfield Security Hospital, was officially opened on campus on 23rd June, 1987. It is the only purpose-built unit for the treatment of prisoners with psychiatric illnesses within a psychiatric hospital in Australia." Admittedly, the move was prompted by a fire at Yatala Prison which destroyed blocks of cells, and the incorporation of the 60 beds at the Security Hospital was seen as a way of assisting the gaol. It was also welcomed by the Hillcrest administration and medical staff. Both Bill Cramond and I still believe that the placement of a maximum security hospital for mentally ill offenders on the campus of a modern psychiatry hospital is inadvisable.

Willis House has never functioned effectively as an inpatient unit. The first sad setback was when Dr. Barbara Meyler, the Child Psychiatrist who was to have run the unit and whose brainchild it largely was, died suddenly. The second was when patients and staff of the adolescent unit were rejected by the patients and staff at the adult Enfield Hospital. My idea, that the adolescents, as in the standard home environment, would have their own school, work, and recreational areas and quiet accommodation for sleep and escape, but meet with adults over meals and for social intercourse, was a complete failure. I and the members of the committee who had made the decision to establish an adolescent unit had made an error of judgment. Rather, I think the decision was right in theory; it was people who made sure it would not work. In my disappointment, that was how I felt then. I was probably wrong, for it continues to function effectively as an outpatient and day patient facility, but not as an inpatient unit. At least Willis House is still there; Enfield has gone.

In Chapter VII, I reported that Joe Craig believed that Bill Cramond promoted the construction of Strathmont Centre as a first priority only because he knew that he had to separate the intellectually retarded from the mentally ill before he could proceed with his top priority, the redevelopment of Glenside Hospital. This need to upgrade the outdated accommodation and facilities at Glenside was never lost sight of in the ensuing years. In April, 1974, following discussions between representatives of the Hospitals Department, Mental Health Services, Public Buildings Department and Glenside Hospital, a four stage plan was formulated. The first stage, a sub-acute ward, named The Glen, was completed in 1976. Stage 2

of Glenside Hospital Redevelopment was officially opened by the Hon. D.H.L. Banfield M.L.C., Minister of Health on 9 March, 1979. It consisted of three buildings:

Brentwood Ward was a maximum care ward with 40 beds, to be used as the acute admission and assessment area for the hospital for the small percentage of patients who required supervision and treatment in a closed ward setting. There was a small eight bed secure wing for acutely disturbed patients; and a 32 bed area for less disturbed people and for those transferred from the intensive treatment area.

The Birches consisted of two 32 bed sub-acute wards and was almost identical with The Glen, which was completed in 1976 as Stage 1 of the development programme.

Downey Grove had four 32 bed units spaced around two open courtyards. Each unit could be sub-divided into smaller groups of patients. This 128 bed psychogeriatric wards building accommodated those elderly and often frail people who formerly lived in sub-standard conditions in holdings erected at the turn of the century. Air-conditioned, it was located close to Downey House, the psychogeriatric assessment centre.

As Director-General of Medical Services, I took part in the opening ceremonies. I said:

"In the 11 years since I joined the Hospitals Department as Director of Mental Health Services I have been actively involved in the redevelopment of Glenside Hospital. It has been an exciting and profitable time working with the Hospital Redevelopment Committee and architects of the Public Buildings Department in the construction of the new buildings to replace the old, inadequate accommodation.

"The new buildings have been designed largely upon multiples of the eight bed unit first seen in the 32 bed villas of the Strathmont Centre. Add to this basic concept a large central area, like the foyer of an hotel, where much activity occurs, where the people from the hospital community and visitors from the outside community can mix and from which all facilities can be reached, and multipurpose rooms for group therapy or quiet relaxation, and we end up with a building in which a small group, a larger group or the whole ward can become involved in varied activities according to patient needs or the therapeutic programme.

"Some buildings are already being used for purposes somewhat different from those for which they were planned demonstrating the flexibility of design that makes adaptation easily possible.

"I find it most satisfying to see that a large 120 bed unit for psychogeriatric patients can be so attractive functionally, so compact, so efficient and so friendly and to know I had a hand in it.

"It is gratifying to see Stage II of the redevelopment completed on the eve of my retirement. I believe that the new wards and those to follow are leaders in the field of psychiatric hospital architecture. They stand as a credit to all concerned."

The redevelopment was completed with the opening of a new Canteen in January, 1984, which would become an important part of the village square concept planned for that part of the Hospital, and of the Cedars Medical Complex in November, 1984. The latter incorporated three wards that provided excellent accommodation and facilities for managing those patients who were transferred from other wards for the assessment and treatment of physical illnesses.

Hillcrest Hospital was not overlooked. A modern psychogeriatric unit⁵ similar to that at Glenside, plus a twenty-five bed unit for the treatment of patients with schizophrenia, was opened in November, 1982.

On September, 1983, Hillcrest Hospital was accredited by The Australian Council of Hospital Standards (now The Australian Council on Health Care Standards) as a hospital of excellence for the full three-year term; the first psychiatric hospital in Australia to be so honoured.. Glenside Hospital followed in April, 1987.

The administration of the Mental Health Act has been plagued by uncertainty because of a number of changes in the composition and objectives of the South Australian Health Commission. As recommended in the Bright Report⁶ the Mental Health Services were incorporated as far as possible with the general health services. Glenside and Hillcrest Hospitals were incorporated under the Health Commission Act and administered by their own Boards of Management. In 1981, I became Deputy Chairman of the Glenside Hospital Board for its first two years of operation. The Community Mental Health Centres and the various other community services functioned satisfactorily. There was concern, however, in the attitude that the

Health Commission exhibited to the position of Director of Mental Health Services and the role the occupier of this position should play. I had always believed that such a person would be required. That was why the Director was made responsible for the administration of the new Mental Health Act. Part II, Division I, of the Act read:

"6. (1) There shall be a Director of Mental Health Services

7. (1) Subject to subsection (2) of this section, the Director shall have the general administration of this Act.

(2) In the administration of this Act, the Director shall be subject to direction by the Commission.

8. (1) The Director shall, before the thirty-first day of December in each year, submit to the Commission and the Minister a report upon the administration of this Act during the twelve months ending on the preceding thirtieth day of June"

Some in the Health Commission could see no reason for a Director and foisted the nominal position on to people poorly equipped for the task and with little interest in it. I always believed that the main reason for retaining a designated figure as Director was the important role he played in acting as an advocate for patients and as the person to whom harassed or disturbed relatives could turn. Fortunately, the need for this role gradually became abundantly clear and the position has been retained.

With the proposal to establish a new Guardianship Board under a Guardianship and Administration Act, separate from the Mental Health Act, it will be fascinating to discover what the newer Mental Health Act proposes.

NOTES.

Chapter 1.

1. Prince Alfred College, Kent Town, Adelaide - a Methodist private school for boys in 1928-1932.
2. Dr. F.R. Wicks, known as 'Waldo', a general medical practitioner at Murray Bridge, a town on the River Murray 81 km. east of Adelaide.
3. Woodside Army Camp - situated in the Mt. Lofty Ranges, east of Adelaide.
4. A.I.F. - the Australian Imperial Forces, the expeditionary forces that served outside Australia in World Wars I and II.
5. Photographic illustrations of some of these devices can be found in the book *Hillcrest Hospital: the First 50 Years* by Averil G. Holt, 1979, commemorating the Golden Jubilee of Northfield Mental Hospital 1929-1964, Hillcrest Hospital from 1964.
6. Enfield Receiving House, opened in 1922, is now demolished.
7. Holt *op. cit.* p.3.
8. Medical Superintendent, Repatriation General Hospital, Keswick.
9. Keswick Hospital - situated on Anzac Highway, adjacent to the Military Barracks. Repatriation Department patients were treated there till the Department took over the 105 Adelaide Military Hospital, Daw Park.

Chapter 2

1. Dudley Byrne - became a specialist in Obstetrics and Gynaecology and a visiting surgeon to Parkside Mental Hospital.
2. See page 66.
3. Lothar Hoff - Superintendent of Glenside Hospital.
4. Colin Haynes - see pages 125-126.
5. Howard Lloyd - see Chapter 6.
6. Dr. W.E. Mickleburgh - first Director of "Carramar" Mental Health Centre, Greenhill Road, Parkside, and Community Psychiatrist; Chairman of Rehabilitation Committee and later President of South Australian Association for Mental Health.

7. Pat Loftus - the first psychologist in the Mental Health Services. Became involved with the development of Industrial Therapy.
 8. SP or "Starting Price" bookmakers were illegal off-course bookmakers who took bets from punters and paid on the starting price of the horses which won a race or gained a place.
 9. Eric Cunningham Dax - Chairman, Mental Hygiene Authority, Victoria.
 10. Bowlby, J. (1951). *Maternal Care and Mental Health*. Geneva: WHO; London: HMSO; New York: Columbia University Press. Abridged version, *Child Care and the Growth of Love*, Harmondsworth: Penguin Books, 2nd edn, 1965.
 11. See Chapter 6, page 130.
 12. These courses and the work of the Mental Health Visitors were discussed in detail in two articles: Barbara Franck, 1966. *In-Service Training for Mental Health*. British Social Work Journal Case Conference, Vol 13, No 1; Barbara J. Auld, 1977. *The Mental Health Visitor and Psychiatric After-Care*. Medical Journal of Australia. Vol 1, No 17, pages 622-627. An abstract of the latter also appeared in the USA Community Mental Health Review Periodical, "Psychiatry Digest", Illinois, in April, 1978.
 13. Mrs. Dorothy Pryce - a senior social worker attached to the Headquarters staff of the S.A. Mental Health Services.
 14. Ross, T A. *The Common Neuroses*, Edward Arnold & Co. London. First published in 1923.
 15. G.P.I. - General Paralysis of the Insane; involvement of the central nervous system in tertiary syphilis.
- > 16. Section 21 leave - full time medical officers in the State Mental Health Services used to be entitled by law to six months leave on full pay after every five years of service. This was to compensate them for the week end and night duties they had to carry out. It was subsequently stopped. Dr. Lothar Hoff was the last recipient.
17. Cawte. John, 1974. *Medicine is the Law. Studies in the Psychiatric Anthropology of Australian Tribal Societies*. The University Press of Hawaii. Honolulu. Other publications are:
Cawte. John, 1972. *Health in a Developing Country. Principles of Medical Anthropology in Melanesia*. (with R.M. Pulsford). Jacaranda Press, Brisbane.

- Cawte. John, 1972. *Cruel Poor and Brutal Nations. Assessment of Mental Health in an Australian Aboriginal Community*. The University Press of Hawaii, Honolulu.
- Cawte. John, in preparation: *Rallying from Breakdown - without Tranquillizers. Enfield Receiving House 1951-56*.
18. *The Hyperventilation Syndrome*. The Medical Journal of Australia, Vol. II. No. 12, pages 409-416, September 17, 1949.
 19. St. Anthony's Private Hospital, Fifth Avenue, Joslin - a private psychiatric hospital later taken over by the Alcohol and Drug Addicts Treatment Board.
 20. St. Margaret's Private Hospital, Payneham Road, Payneham - a private psychiatric hospital, later sold to the Commonwealth Government and used as a rehabilitation centre.
 21. See Section (x), pages 76-78.
 22. *Lithium Salts in the Treatment of Psychotic Excitement*, The Medical Journal of Australia, No. 36, Page 349. 1949.
 23. *Iproniazid ("Marsilid") in the Treatment of Depression*,
The Medical Journal of Australia, Vol. II, No. 10, pages 308-311. September 5, 1959.
 24. *Problems of Behaviour and Learning and Cerebral Dysfunction*, Journal of the Australian College of Speech Therapists, Vol. 16, No. 2, pages 41-46. December, 1966.
 25. Alan Stoller - Army psychiatrist, later Consultant (Psychological Medicine) Repatriation Commission HQ; then Chief Clinical Officer, Mental Hygiene Authority, Victoria.
 26. The early history of the South Australian Association for Mental Health and the Australian National Association for Mental Health is contained in the booklet *Mental Health Associations in Australia - Their Beginnings and Growth*, an Occasional Paper published by the Australian National Association for Mental Health, April 1973.
 27. Ross Kalucy - Professor of Psychiatry, the Flinders University of South Australia. See Introduction.
 28. Kenneth Cameron - Head of the Department of Child Psychiatry at the Maudsley Hospital.
 29. Bill Salter commented: "A gross exaggeration!"

30. Salter explained that the specimens were to have become the beginning of a Pathology Museum; but this idea came to nothing when the bodies from Northfield Mental Hospital were sent to Royal Adelaide Hospital for autopsy.

Chapter 3.

1. see Chapter 8, pages 153-158.
2. Premier of South Australia for 26 years and 226 days - see *Playford - Benevolent Despot*, by Stewart Cockburn, Axiom, South Australia, 1991.
3. see pages 110-113.
4. *Mental Health Services in South Australia and Overseas*. Two Reports by W.H. Trethowan (1959) and J.E. Cawte (1957). S.A. Association for Mental Health Incorporated, Occasional Papers for Private Circulation, 1960.
5. see pages 106-107.
6. a Theatre-in-the-Round, then privately conducted by John Edmonds, in the suburb of Hilton.
7. see attached copy of letter to Dick Oaten.
8. see attached copies of correspondence with A.B.C.
9. see attached programme for psychodrama.
10. see note 28, Chapter 2.
11. a respected, forward-thinking general practitioner in the Adelaide Hills, and a great supporter of the South Australian Association for Mental Health in its beginnings. A founder of the Royal Australian College of General Practitioners.
12. see attached list of names for Committee of Sponsors.
13. A member of the Council of the S.A. Association for Mental Health and Chairman of the Community Education Committee - pages 117-118.
14. Appendix 2.
15. see note 6, Chapter 2.
16. see correspondence with the Premier, Steele Hall.

Chapter 4.

1. *A Textbook of Psychiatry for Students and Practitioners*, Sir David Henderson and R.D. Gillespie. 9th ed. Oxford University Press, London, 1962

Chapter 5.

1. named after Dr. W.L. Cleland, Superintendent, Parkside Lunatic Asylum, 1878-1913.

Chapter 6.

1. Previous reference in note 4, Chapter 2.
2. a Hospital and Training Centre for the mentally (intellectually) retarded - see Chapter 7.
3. Supervising Design Architect with the S.A. Public Buildings Department - see Chapter 7.
4. "Dictionaries describe Ha-Has as sunken walls bounding parks and gardens. A story circulated in the early days goes something like this. A newly admitted patient, when he was allowed out into the airing court or exercise yard, noticed the low wall and he immediately had visions of an early escape. However when he decided to put his intention into practice and made his approach to the boundary wall, he was affronted with the moat going to the base of the wall. Realising that his visions of an easy scale over the wall had been thwarted, he became dejected and this was noticed by another patient who muttered "Ha-Ha" and the would-be escapee walked away."
1870-1970. - Commemorating the Centenary of Glenside Hospital, prepared by H.T. Kay, page 32.
5. Chapter 2.

Chapter 7.

1. see Plan 1 - Strathmont
2. Architect with Public Buildings Department.
3. see Plan 2 - Willis House and Plan 3 - Litchfield House.
4. see Plan 4 - psychogeriatric ward at Hillcrest Hospital.

Chapter 8.

1. see Chapter 2, pages 61-69.
2. Director of the Department and one of the first child psychiatrists in Australia.
3. a senior Melbourne neurologist.
4. see Chapter 7.
5. First Lay Superintendent of Northfield Mental Hospital; later Lay Superintendent of Royal Adelaide Hospital; then a Deputy Director General in Hospitals Department - see Chapter 9.
6. see Chapter 2, pages 39-46.
7. Psychiatrist in Private Practice. See Chapter 11, page 217.

8. A senior specialist physician at Royal Adelaide Hospital.

Chapter 9.

1. see note 4, Chapter 6.
2. see Plan 5 - Security Hospital.

Chapter 10.

1. *In the Looking Glass*. The Australian and New Zealand Journal of Psychiatry, Vol. 1. No. 1. Pages 7-13, March 1967.
2. Szasz, T.S. (1964) *The Moral Dilemma of Psychiatry: Autonomy or Heteronomy*. American Journal of Psychiatry, Vol. 121, Page 521.
3. Wootton, B. (1959) *Social Science and Social Pathology*. George Allen and Unwin Ltd., London.
Wootton, B. (1963) *The Law, the Doctor and the Deviant*. British Medical Journal, Vol. 2, Page 197
4. Adrian, Lord. (1956) *Organizers of Health*. British Medical Journal, Vol. 1, Page 1189.
5. Lindner, R. (1952) *Prescription for Rebellion*. Rinehart and Company, New York.
6. Sargant, W. (1957) *Battle for the Mind*. Wm. Heinemann Ltd., London (1959) Pan Books Ltd., London.
7. Southwood, H.M. (1961) *The Psychiatrist and the Public*. Medical Journal of Australia, Vol.1, Page 771.
8. Kittrie, N.N. (1971) *The Right to be Different*. The Johns Hopkins Press, Baltimore and London.
9. Ullmann, L.P. (1967) *Institution and Outcome: A Comparative Study of Psychiatric Hospitals*. Pergamon Press, Oxford.
10. see Chapter 4.
11. *Uniform Principles Involved in Mental Health Legislation*, see Appendix II.

Chapter 11.

1. *Commitment and Discharge of the Mentally Ill in South Australia*. Adelaide Law Review (1972) Vol. 4, No. 2, Pages 330-364.
2. *Report of the Committee of Enquiry into Health Services in South Australia*. Adelaide, 1973. ("The Bright Report")
3. *Criminal Law and Penal Methods Reform Committee of South Australia*. 5 volumes, Government Printer, Adelaide, 1973-1977.

4. Mental Health Act 1933-1969. Part III, Division II.
5. see page 205.
6. Minute dated 22 April, 1974 in P.T. 35/74.
7. prepared by the Hospitals and Health Services Commission and published by the Australian Government Publishing Services, Canberra, 1974.
8. *The Future of the Mental Hospital*. The Medical Journal of Australia, Vol. 2, No. 11, Pages 577-578, September 9, 1972.
9. see Appendix HI.
10. see Appendix IV.
11. see Appendix V.
12. see Appendix VI.

Chapter 12.

1. see Appendix VI.
2. see Appendix VII.
3. see Appendix VIII (a), (b) and (c).

Chapter 13.

1. see Appendix IX.
2. see Appendix X.
3. see Appendix XI.
4. see Appendix XII.
5. The South Australian Government Gazette, February 22, 1979.

Epilogue.

1. *Mental Health and Law Reform: the "Second Wave"*. The Medical Journal of Australia, Vol. 1, Pages 421-425, April 18, 1981.
2. Adams, N.H.S. and Hafner, R.J. *Attitudes of Psychiatric Patients and their Relatives to Involuntary Treatment*, Australian and New Zealand Journal of Psychiatry, Vol.25, No. 2, Pages 231-237, June 1991.
3. *Review of the Guardianship Board and Mental Health Review Tribunal*. May 1989. South Australian Health Commission.

4. *Hillcrest Hospital Biennial Report 1987-89: Celebrating our Diamond Jubilee.* Printed by Hillcrest Hospital.
5. See Plan 4, in Chapter 7, note 4.
6. See Chapter 11, note 2.