The Rise of Psychiatry and its Establishment in Queensland

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Psychiatry emerged as a distinct discipline around about the last decade of the eighteenth century. By that time those suffering from mental illness were treated "on medical rather than moral lines"[1]. Medications were employed, as had been done for a very considerable time [2], along with electric shock therapy [3]. Specialist psychiatric practitioners had come of age. George III, making one of his periodic contributions to the field, fell into a delirium impervious to the armamentarium of his personal physicians and on 5 December 1788 had summoned to his bedside a specialist in mental illness, Francis Willis[4].

With recourse to the embryonic psychiatric profession being had by those of status, the practitioners' self-image improved from that of common mad-doctor to medical specialist. In 1841 the Association of Medical Officers of Asylums and Hospitals for the Insane was inaugurated. A quarter of a century later it became the Medico-Psychological Association, metamorphosed into the Royal Medico Psychological Association in 1926 and, most recently, in 1971, into the Royal College of Psychiatrists. With organisation came the ability to influence the Legislature.

In Australia, the legal and practical treatment of the mentally ill conformed to that developed in England. Indeed, the worst features of Bedlam were dutifully copied. In Tasmania, an asylum attached to the hospital at New Norfolk, near Hobart, was opened in 1829. In 1844 the Colonial Times voiced the criticism that apparently no attempt was made to cure the patients, they being simply kept locked up[5]. One of the more kindly comments made in regard to the institution in the mid nineteenth century was that sightseers had been prohibited and patients were no longer made sport of for the amusement of visitors[6].

An indicator of just how slowly attitudes and practices did change is to be found in the routines of the Goodna Asylum in Queensland

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where, in 1910, the new superintendent was irritated to discover that seclusion and restraint were common and that croton oil was still being used as a violent purge in order to discipline obstinate cases[7]. Scandals of one sort or another surfaced periodically; cruelty to patients led to staff dismissals[8], overcrowding occurred due to lack of funding, staff vacancies remained unfilled[9], and sexual scandals brought official inquiry. Indeed, not long after the Woogaroo Asylum opened in Queensland in 1865 a sexual scandal involving a female patient precipitated an inquiry into conditions there[10]. Conditions did not appear to have changed, at least not for the better, as in 1869 a visiting doctor found patients ankle-deep in mud in their exercise yard[11]. Concern bloomed with each new scandal and faded when public attention moved to other areas. The cycle of unfulfilled promises of reform continued at least until 1915 when another inquiry showed that little had changed in half a century[12].

Still trailing behind the English model, New South Wales passed the first Australian legislation dealing with insanity, the Dangerous Lunatics Act 1843. The separation of Queensland from New South Wales in 1859 transferred the statutes then in force. The late 1860s saw a select committee propose a complete legislative overhaul, to little avail. Yet another inquiry, over a decade later, proposed new legislation which was enacted as the Insanity Act, 1884. Paralleling the then recent New South Wales legislation, it allowed for admissions on the initiative of relatives, for patients to be granted leave of absence, and for the appointment of Official Visitors to the Woogaroo Asylum. Oversight was to be strengthened by an Inspector of the Insane. This regime was to remain virtually unchanged until just before World War Two.

The major asylums, most still enjoying that distinction today, were laid out on spacious grounds in rural or semi-rural areas, in the pattern recommended in 1868 by Frederick Norton Manning, a London-trained physician. While Superintendent of Tarban Creek asylum in New South Wales, Manning had reported on asylums in the United States, United Kingdom and Europe after a study tour. He advised that there should be an Inspector-General of the Insane, a board of inspection and a board of control exercising powers over staff, finance, and the admission and discharge of patients[13]. This approach reflected the growing stature of psychiatry.

The belief held by practitioners that treatment ought to be commenced well before a patient became certifiably insane and thus legally eligible to be admitted to an asylum brought psychiatrists to openly challenge the existing laws, applying pressure for change. By 1906 the medical profession in Australia was expounding the doctrine that patients ought to be able to be voluntarily admitted for treatment.

At that time it was believed that early intervention would lead to reducing the numbers eventually needing to be institutionalised. The doctors also sought to encourage the community to take the view that mental illness ought no more to be the subject of a stigma than physical illness[14].

Leading practitioners of the day, influential at the policy level, weighed in. Eric Sinclair, New South Wales Inspector-General of the Insane, joined the battle against the pre-eminent influence of the legal profession, exercised through the guardianship of individual liberty. The psychiatrists did not limit themselves to working within laws already drawn so as to deny them their goal of early intervention. They applied their efforts not towards winning a change of opinion from lawyers who then might magnanimously exercise their influence to change the interpretation or, through the Parliament, the wording of the law; instead they proceeded to the root of the problem. The statute law conflicted with what they perceived to be needed; the solution was to change the law as well as the policy behind delivery of psychiatric services. In 1914, Sinclair wrote to the New South Wales Premier, William Holman:

> The lunacy laws in the past have taken more care of the legal requirements than of the medical and have laid much stress on the protection of the liberty of the subject, as to require the patient's disease to remain undealt with until an advanced stage[15].

That same year saw Sinclair's Victorian counterpart address the Australasian Medical Congress:

> We must shape our endeavours to obtaining from our various legislative bodies the recognition of the voluntary principle without which we cannot hope to do more than make very limited progress[16].

The argument was put to the politicians directly and to the rest of the medical profession by way of conference papers and journal articles[17]. Practical action was also taken at the level of administrative policy. In South Australia, following years of lobbying, Enfield Receiving House was opened in 1922 to provide psychiatric treatment for patients without a need for them to be first certified insane. The law was adjusted to the new reality by a 1922 amending Act which allowed for voluntary admissions[18]. The psychiatrists had gained the ascendancy, making changes and leaving the law to scamper along behind.

The agenda included bringing psychiatric patients into general hospitals in order to remove the stigma of mental illness. The Public Hospital in Perth, Western Australia, had opened a psychiatric ward in 1908, leading Australia in this[19]. In Queensland, Dr. H.B. Ellerton, Inspector of Hospitals for the Insane, proposed that early

treatment wards be opened in general hospitals, Brisbane General Hospital leading the State by opening its first psychiatric ward in 1918[20]. Unfortunately, the Brisbane Hospital, controlled by its own Board, allowed standards in the psychiatric unit to slip below those prevailing in the Hospital generally, with patients being inadequately cared for and, all too often, certified and moved on to Goodna, the new name for Woogaroo asylum[21].

At Goodna, conditions were far from ideal. In 1915 the Brisbane *Daily Mail* began a crusade against conditions in the Goodna Asylum, leading off mid-year with an article headed "Asylum Horror. Shocking Conditions at Goodna — Patients Scandalously Neglected — Rat and Vermin Infested Wards — Inadequate Medical Staff"[22], managing handily to insert "shock", "horror" and "scandal" into the one heading. Continuing pressure from the press caused the then newly elected Ryan Labor Government to appoint a Royal Commission, the original article having called for an inquiry into the asylum where inmates were said to be treated more as "imprisoned animals" than "victims of mental derangement"[23].

The Royal Commission sat and Dr Ellerton, newly appointed as Superintendent, gave evidence of inadequate staff numbers. The Commission reported that an excessive use of restraint and seclusion was employed due to the staff shortages but that:

> . . . the charges made against the medical staff of neglect, cruelty to and mental torture of patients . . . were . . . made recklessly and without justification[24].

The Commission did, however, find overcrowding and poor sanitation, rats and bedbugs as well as theft of hospital food stores[25]. No significant development flowed from this inquiry; it was rather the case of a building inspection being conducted to locate the rats and other vermin and an investigation of some criminal conduct, no more than that. No-one looked at policy-level improvements; the hospital medical and administrative staff directed their energies towards defending themselves from the allegations made against them. Their emphasis was very much on simply holding their ground.

Their strategy did not change. It next bore fruit when, in 1937, after Dr Ellerton's retirement, Dr Basil Stafford, at the time Superintendent of Ipswich Asylum and later to become Director of Mental Hygiene, was sent to Europe and America on a study tour[26]. Dr Stafford's report formed the basis of the Mental Hygiene Act 1938[27]. Moving the second reading of the Bill, the Secretary for Health and Home Affairs, E.M. Hanlon, announced what the psychiatrists had waited so long to hear, that voluntary treatment was to be available at mental hospitals, ". . . just as a physically ill patient may obtain treatment at a hospital . . .". At last patients could seek help from mental

hospitals without the stigma of first meeting the old legal requirement of being declared insane. The legal barrier between sufferer and treatment had finally been swept aside[28]. In this the doctors had prevailed; the law would no longer stand in the way of treatment and there would be ". . . no reason why every case of [schizophrenia] should not be cured so long as treatment is given early"[29].

The 1938 Act, in making provision for voluntary patients, followed the English Act of 1930[30]. The administration of public mental health care was made the responsibility of the Director of Mental Hygiene who was answerable to the Director-General of Health and Medical Services. Both officers were to be given the powers of a royal commission when inquiring into anything to do with a mental institution[31]. This would presumably allow the profession to itself deal with problems and scandals, barring the door to what might be hostile inquiries conducted by those with incompatible professional outlooks.

In keeping with the therapeutic emphasis, the words "insanity", "lunacy" and "asylum" which had characterised the Insanity Act of 1884 were replaced by the terms "mental sickness" and "mental hospitals"[32]. Hanlon emphasised that the change in terminology was to "put it into people's minds"[33] that what was being provided was a medical service[34] and not a dumping ground for the unwanted. He also told the House that "We are starting a little institution at Townsville . . . and as time goes on that institution will serve that division of the State"[35].

Having gained a very large measure of control over patients and allowed easy entry to the mental hospitals, the psychiatrists proceeded to apply the then-current medical treatments to their patients. Some treatments were dangerous in the extreme. Schizophrenia, the mental disease marked by disconnection between thoughts and actions and frequently accompanied by bizarre delusions, was attacked with such weapons as insulin-induced shock, a lengthy, expensive and dangerous treatment requiring constant medical attendance. Pioneered by the Viennese psychiatrist Dr Manfred Sakel[36], it was soon used at the Brisbane Mental Hospital. Also applied was fever therapy, for which Wagner von Jauregg received the Nobel Prize for Medicine in 1927. Using strains of benign tertian malaria, patients suffering from general paralysis of the insane were infected in an attempt to cure those whose lives were otherwise usually limited to two to three years[37]. The danger and cost of insulin therapy for schizophrenia, as well as its unreliability, led to employment of the more economical and less toxic cardiozol which however brought with it frequent fractures caused by convulsions[38]. With the medical profession firmly in charge of the welfare of the mentally ill, modern innovations rapidly found their way to the Brisbane Mental Hospital at Goodna. Electroconvulsive

therapy was applied at Goodna in the 1940's[39] after first being tried in South Australia in 1941 by H.M. Birch, using a device he built himself, the outbreak of World War Two having prevented the importation of a machine from England[40]. This very new treatment had enjoyed its world premiere in 1938 in Rome, after Ugo Cerletti had noticed that pigs slaughtered at a Rome abattoir were first rendered insensible by electric shock[41].

Advances in treatment, particularly the introduction of efficient tranquillising drugs and sedatives, allowed the profession to lay claim to curing many patients. In 1962 the Minister for Health and Home Affairs, Dr W.H. Noble, in his second reading speech, told the House that "Revolutionary therapies" such as cardiozol, insulin, electrotherapy and the new drugs allowed cures in the general hospitals[42]. The 1962 Bill would allow persons suffering from mental illness to be admitted to any hospital, general or mental, with no more formality than that needed for a person to enter a hospital for treatment of a physical illness[43]. For clerical neatness, the Bill introduced safeguards to ensure that patients were not "lost" in the system[44].

The battle had been won, the struggle with the law and its obsession with freedom, the "fetish of liberty" as the psychiatrists had labelled it sixty years before[45], was over; benevolent legislation would ensure that patients were not misplaced, thus preserving their rights. The 1962 Bill, said the Minister, in fact recognised that some patients had no wish to leave[46], the patient's status would therefore be required to be reviewed before the expiration of 12 months in hospital and, ultimately, every 24 months to avoid them becoming institutionalised[47]. Also introduced were Mental Health Review Tribunals to which a patient or relative could appeal in respect of the patient's treatment or detention[48]. Official visitors could be appointed[49] and were empowered to visit hospitals without notice, reporting their findings to the Director of Psychiatric Services[50].

The provision relating to admissions made without compulsion of law is somewhat euphemistically referred to as "Informal admission of patients"[51]. The Minister, stating that the aim of the proposed legislation was to remove the stigma of mental illness, so that the community would accept it as just another illness[52], was re-stating the profession's aim since the start of the century. Just how this was to be brought about is particularly instructive. Because mental illness was just another illness, then the patient ought to be able to be admitted for treatment without any sort of form or medical certificate, following "arrangements made by his medical attendant"[53]. The Minister regarded this concept as one "of such extreme importance"[54] that he was moved to quote what became section 17

of the Act. It referred not to voluntary but to "informal" patients and the Act, like the Bill, made no requirement that the arrangements be made even by the patient's doctor, simply that they be "made in that behalf", that is in order for the patient to be treated for mental illness.

The legislation had indeed taken a course that was of extreme importance, it permitted admission to a hospital, including a mental hospital, for treatment of a mental illness, no doubt with recourse to the contemporary armamentarium already referred to, without any need for consent to be obtained from the patient, acquiescence being sufficient. In the case of those who declined to be treated, the Bill allowed a justice of the peace, on sworn information, to issue a warrant for the apprehension of the unfortunate by a police officer or, in cases of emergency, for the police to act on their own authority, removing the person to a place of safety, preferably but not necessarily a hospital[55]. Upon reaching a hospital, the patient's case would be reviewed at prescribed intervals, a system re-enacted at the time of the next major review of the legislation, in 1974. By this time, psychiatric control over the content of the legislation was a given. Administrative policy, said the Health Minister in his second reading speech, was more important than what the Act said in any event[56]. The Act was to be administered by the Director of Psychiatric Services, the Director-General of the Health Department and, of course, the Minister[57]. The Minister expressed the view that no person ought to be deprived of liberty or subjected to medical procedures against their will unless such action was "clearly necessary", for instance if the person was dangerous.

The Minister said that it was not in the patient's interests that the provision of treatment should depend "on argument about fine points of law, or on the existence of legal loop-holes"[58]. Such arguments, no doubt, as might be expected to be raised by lawyers representing patients who might adhere to a competing view to that held by the doctors. Patient Review Tribunals, now to be empowered to order the discharge of a patient, had great power over the individual's liberty. The Minister was of the view that representation of the patient by legal counsel was not appropriate as such could limit the patient's personal involvement[59]. This sophisticated reasoning was carried forward with the specific equating of "informal" with "voluntary" admission of patients[60].

The Bill became the Act of 1974, but not before Dr Scott-Young, member for Townsville, delivered these encomiums:

> In Townsville, . . . mental patients are now cared for in air-conditioned comfort on two floors that are magnificently appointed and contain both recreational and diversionary therapy rooms and equipment. The wards are magnificently furnished and are kept

abreast of the constant rethinking and upgrading of the State's psychiatric services by the Minister and his predecessor and their departmental officers[61]

The Act as it stood then was what it remains now, the psychiatrists' Act, the lawyers having been driven from the field.

ENDNOTES

1. Lewis, Sir Aubrey. 1967. *The State of Psychiatry.* London: Routledge ¿ Kegan Paul. p.7.
2. Jones, John. 1700. *The Mysteries of Opium Reveal'd.* London: R. Smith. 88-89. Digitalis was also used. Withering, William. 1785. *An Account of the Foxglove, and Some of its Medical Uses.* Birmingham: Robinson.
3. Hunter, Richard. 1957. "A Brief Review of the Use of Electricity in Psychiatry". *British Journal of Physical Medicine.* n.s. 20:99.
4. Porter, Roy. 1990. *Mind-Forg'd Manacles.* London: Penguin. p.175.
5. Lewis, Milton. 1988. *Managing Madness: Psychiatry and Society in Australia 1788-1980.* Canberra: Australian Government Publishing Service. p.6.
6. ibid.
7. ibid. p.14.
8. ibid.
9. ibid. p.18.
10. ibid. p.19.
11. ibid.
12. ibid.
13. ibid. p.15.
14. "Treatment of the insane in New South Wales". 1906. *Australasian Medical Gazette.* November 20. pp.587-8.
15. Lewis, Milton. 1988. p.34.
16. ibid.
17. "The rational treatment of incipient insanity". 1914. *Australasian Medical Gazette.* April 11. pp.319-20.
18. Mental Defectives Act Amendment Act of 1922. Sections 23-30.
19. Lewis, Milton. 1988. p.36.
20. ibid.
21. ibid. p.38.
22. ibid. p.46.
23. ibid.
24. Queensland, Parliament 1915-16. *Royal Commission on Management of Hospital for Insane, Goodna.* Parl. Paper 1915-16, Vol. 3, 87-658. 114.
25. ibid. p.90.
26. Queensland Parliamentary Debates (hereafter QPD) 19 October 1938 p.1043. See also *Stafford,* Basil F.S. 1938. *Report on Modern Trends in Administration and Treatment of Mental Diseases.* This internal report was presented to the Hon. E.M. Hanlon M.L.A., Minister for Health and Home Affairs, upon Dr Stafford's return from his study tour of New Zealand, the U.S.A., the U.K. and Europe and was not published.
27. ibid. See also Hanlon's speech notes to like effect. Queensland State Archives. A/31776. 1938. "Mental Hygiene (Insanity) Generally". Archival holdings of Home Affairs material for the period 1902-1938 do not indicate the presence of any submissions complementary to or competing with Dr Stafford's report or that any opinions were sought on it before it was acted upon.

28. ibid. p.1045. See also *Stafford,* Basil. 1938, p.6-7.
29. ibid.
30. Ibid. p.1057. See also *Stafford,* Basil. 1938, p.7.
31. ibid. p.1045.
32. ibid. p.1047. See also *Stafford,* Basil. 1938, p.6.
33. ibid. p.1068.
34. ibid.
35. ibid. p.1069.
36. ibid. p.1060. Hansard has recorded his name as Nanfred Sarkel, reflecting the then widespread unfamiliarity with this esoteric area, even among the better informed.
37. Lewis, Milton 1988 p.43, 47.
38. ibid. p.222 n.8.
39. ibid. p.48.
40. ibid. p.45.
41. ibid. p.222 n.8.
42. QPD 5 December 1962, p.2211.
43. ibid.
44. ibid.
45. Lewis, Milton, 1988, p.34.
46. QPD 5 December 1962, p.2211.
47. ibid.
48. ibid. p.2212.
49. Mental Health Act of 1962. Section 12.
50. ibid. Section 13.
51. ibid. Section 17.
52. QPD 5 December 1962 p.2213.
53. ibid.
54. ibid.
55. ibid. p.2214.
56. QPD 12 March 1974, p.2218.
57. Mental Health Services Act 1974. Section 7.
58. QPD 12 March 1974, p.2817.
59. ibid. p.2819.
60. ibid.
61. ibid. p.2833.