The arts of care in an asylum and a community 1925-2004: Kenmore Hospital, New South Wales and Canberra, the Australian Capital Territory

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February 2009

A thesis submitted for the degree of
Doctor of Philosophy of The Australian National University

This thesis contains no material which has previously been accepted for the award of any other degree or diploma in any university or other institution and, to the best of my knowledge, contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Acknowledgements

I would like to acknowledge the tireless efforts and consistent support of my supervisor, Tim Rowse, throughout my candidature.

The History Program generously provided me with an intellectual ‘home’ and the resources I needed to complete this thesis after my program relocation from Political Science. Friendly and stimulating corridor and coffee conversations with the two Barrys: Professors Higman and Smith, and students, including Elizabeth Ganter, Georgina Fitzpatrick and Laurence Niewójt kept me going. Participation at Australian and New Zealand Society of the History of Medicine conferences and subsequent communications with members reinforced a sense of ‘belonging’ in the history of medicine. Thank you staff, students and members for your support and encouragement.

Thanks to Rupert Gerritsen and Jenny Holmes for providing feedback on an earlier version of the community chapter. Heartfelt thanks to Ed McMahon and Peter Read for thoughtful comments on a thesis draft. Thank you, Karen Smith, for your wonderful support as the History Program Administrator.

I would like to acknowledge and thank Kenmore Hospital for their interest, trust and support; and the volunteers of the Kenmore Hospital Museum, in particular Leonè Morgan. I would also like to acknowledge the support of Mental Health ACT, in particular, Steve Druitt; the Canberra Schizophrenia Fellowship; and the enthusiasm and encouragement of Charlie Pahlman (deceased).

Family, friends and colleagues have had to endure my doctoral studies. I would like to acknowledge with love and respect my children: Chris (and Tegan), John, Rhiannon, Shanti and Kristin, who graciously tolerated my at times physical and mental absences.

Finally, I would like to acknowledge and thank the consumers, carers, and mental health workers whose knowledge and experiences were invaluable in ‘making up’ this thesis. And I would like to pay tribute to a gentle, sensitive and talented man, Greg Smith (deceased).

Abstract

This thesis examines the arts of care in an asylum in New South Wales (NSW) and a mental health community in the Australian Capital Territory in twentieth-century Australia, and describes and compares a range of governmental responses for responding to persons deemed to be in need of care. The thesis explores similarities between twentieth-century Australian care techniques and the key principles underpinning a ‘care system’ that was developed over 200 years ago. It proposes three twentieth-century care regimes, each one characteristic of a certain period: Herd Care, set in an asylum era that emphasised custodialism and confinement (1925-1958); Therapeutic Community, a period during which the asylum was reconfigured into a facilitative community (1959-1983); and Community Care, beginning around 1983, when NSW asylums were ‘rationalised’, their care techniques fragmented and outsourced in diverse settings generally referred to collectively as the mental health community.

Some of the dynamics, continuities and ruptures in twentieth-century care regimes are analysed. Chapters describe the landscapes of care. They explore how environmental settings have been designed to reinforce the care regimes in which they are mobilised and how they ‘make up’ the possibilities for action of the subject of care. The dynamics of care between care providers and their recipients are examined. Some of the continuities and discontinuities of meanings associated with ‘family’ and ‘community’ in each of the care regimes are observed. Fieldwork findings are combined with the cultural narrative of psychiatric primitivism to consider why subjects have been deemed in need of care, at times in need of protection and training and at other times in need of discipline and restraint. The new possibilities for action that have emerged in Australian twentieth-century mental health governance are considered, when subjects of care have been encouraged to learn how to be free.

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1. Introduction

In this thesis I examine the arts of care in an asylum[1] in New South Wales (NSW) and a mental health community in the Australian Capital Territory (ACT)[2] in twentieth-century Australia. Based on data generated from 22 months' fieldwork I describe and compare a range of governmental responses for negotiating the enduring tensions of care - between segregation and integration, regulation and restoration - over a 79 year period. My thesis proposes three care regimes, each one characteristic of a certain period: Herd Care, set in an asylum era that emphasised custodialism and confinement (1925-1958); Therapeutic Community, a period during which the asylum was reconfigured into a facilitative community (1959-1983); and Community Care, beginning around 1983, when NSW asylums were 'rationalised', their care techniques fragmented and outsourced in diverse settings generally referred to collectively as the mental health community. In the chapters that follow, each care regime is examined by focusing on the environmental settings, the care providers they employ, and the possibilities for action (among both the givers and receivers of care) that they give rise to. Interwoven throughout this project are reflections on the political rationalities of liberalism and the narratives of progress and degeneration; on the professional and geographic expansion of public psychiatric practice; and on the data generated by fieldwork in an asylum and a mental health community.

Throughout the following chapters I use the term 'psychiatrically dis-ordered' to refer to those persons who have sought or have been ordered to accept the services of psychiatry and/or mental health services and who have been diagnosed with a psychiatric condition. Dis-order is hyphenated to disrupt a tendency of psychiatric discourse to naturalise and universalise its knowledge claims and secondly, to signal my approach to and understanding of 'madness' as a transgression against culture/order. The concept of 'psychiatric dis-order' is

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[1] By asylum, I refer to an institution variously described over time as lunatic asylum, hospital for the insane, mental hospital, and psychiatric centre. Asylum is used to discomfort and unsettle the reader in a way reminiscent of Goffman's 'challenge' (Reaume 2002:413), of maintaining the tension of its stigmatised association, and resisting the move – by psychiatry and government policy makers – to drape it in medical terminology.

[2] By community, I refer to a governmental and spatial unit of analysis that has been cast in oppositional relation to asylum. The mental health community encompasses families and carers, non-government organisations and their employees, government organisations and their employees working from 'community' health centres and general hospitals. Community also signals a governmental emphasis on the private provision of welfare.

therefore privileged over terms such as ‘mental illness’ in order to emphasise the social aspects of psychiatric classification, diagnosis and treatment.[3] Elsewhere in the thesis, I refer to other forms of agency such as the inmate, the patient and the mental health consumer and, where it is historically appropriate to do so, to the insane and the mad, the inebriate, the epileptic, and the retard.

By emphasising the social and political aspects of psychiatry and psychiatric practice it is not my intention to deny the reality of psychological suffering and periods of mental unwellness. Nor do I envisage the scope of my thesis encompassing any debate about the reality or social construction of a phenomenon described as ‘mental illness’. Rather, I am interested in examining the techniques that have been devised by government to manage psychiatric conditions, and the kinds of possibilities for action they have been productive of, that is, the ‘ecological niches’ for ‘making up’ the psychiatrically dis-ordered (Hacking 1998; 1986).[4]

Three Regimes of Care

The analytical device of periodisation serves various purposes. These include acting as a classificatory device for dividing topics of interest into a chronological trajectory and ordering them into thematic accounts that can explain their constancy and change over time. For example, in her account of changes within psychiatry and the provision of psychiatric services in England, Busfield divides the twentieth century into four periods (Busfield 2004:295-322). Her periods are Custodialism under Attack, 1890-1929; Integration and Medical Innovation, 1930-1953; Community Care and Public Sector Expansion, 1954-1973; and Privatisation and Commercialisation, 1974 onwards. The *Lunacy Act* 1890, emphasising legal concerns around confinement, demarcates the first period; the 1930 *Mental Treatment Act,* encouraging the use of physical treatments and the introduction of open door policies and rehabilitation programs, marks the second; the third period is delineated by the expansion of psychotropic drugs, the growth of psy-professions, the decline of asylum numbers and the development of

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[3] Anti-psychiatry terms such as ‘psychiatric survivor’ and the experience of being ‘psychiatrised’ are also used to draw out political aspects of people’s experiences of being institutionalised and/or of being subjected to psychiatric treatments.

[4] By ‘government’ I refer to ‘“political authorities” and their (professional and technical) counterparts in the “non political” sphere’ (Hazelton 1995:152) and to the complex of relations with community sector workers, carers and families and psychiatrically dis-ordered persons.

community care policies; and the fourth is typified by the rise of neoliberalism and the widespread downturn in public spending (Busfield 2004:298-305).

My periodisation of twentieth-century care in Australia is similarly informed by changes within psychiatry and the provision of public psychiatric services, but it is mainly guided by an interest in exploring the forms of autonomy associated with the psychiatrically dis-ordered in each of the care regimes. I argue that representations of autonomy 'impact upon the range of interventions possible' (Henderson 2005:245). Accordingly, the following chapters examine how governmental constructs of the inmate, the patient and the consumer are attributed with variable capacities for autonomy and possibilities for action that in turn give rise to different care responses.

The concept of autonomy is a cornerstone of psychiatric theory and lunacy laws that has informed both formal and informal arts of care for the psychiatrically dis-ordered. The term 'autonomy' is derived from the Greek *autos* (self) and *nomos* (rule, governance, law) (Lidz, Fischer and Arnold 1992:5). Hindess defines autonomy as the capacity for moral responsibility and rationality and it is this understanding that informs my analysis of autonomy (Hindess 2001). In the chapters that follow, attributes of irrationality and irresponsibility are associated with diminished, impaired or absent autonomy. My understanding of 'autonomous behaviour' in the asylum and the community will seek to be sensitive to context and nuances in the term under each of the three care regimes I have proposed. Accordingly, I argue that it is through subjects acting in accordance with the rules and constraints of particular social environments that 'we can expect to see autonomous behaviour' (Lidz *et al* 1992:88). This stance does not, therefore, exclude the mobilisation of overtly coercive 'interventions', repressive techniques alongside rehabilitative arts of care, to encourage autonomous behaviour

The analysis of liberal governmental rationalities for managing problematic populations through a consideration of their relationship with subjects' capacities for autonomy is not, of course, a novel approach. For example, Hindess's examination of the 'liberal government of unfreedom' proposes three categories of governmental response, linked to individuals' placement on a developmental stage of their attributed capacities for autonomy. He refers to the first category as the 'hopeless cases', those persons who are deemed to be incapable of autonomous action and thus not 'ready for freedom'. The example of indigenous peoples' encounters with agents of Empire is provided, where the indigenous population was presumed to 'die out' in the course of colonisation or, if not, would be helped along the way. Hindess's second category, 'subjects of improvement', refers to those individuals who invoke authoritarian interventions of government, the 'imposition of more or less extended periods of discipline' to reinforce desired attributes of rationality and moral responsibility. A third category Hindess refers to as subjects of the 'ethos of welfare'; they are members of an 'improved population whose condition has been set back by the accidents of ill health, poverty, incomplete education', etc., who elicit a facilitative response from government, one which enhances 'their capacities by establishing a benign and supportive social environment' (Hindess 2001).

Finnane draws on the concept of capacity to inform his periodisation of Australian mental health laws (2003). Tracing the shift from 'dangerous lunatic to human rights', he constructs three, overlapping periods to explain changing understandings of the capacity of the subject and object of government: the era of the 'dangerous lunatic', the era of 'welfare and eugenics', and the era of 'individual rights and entitlements'; each period, however, 'never quite being replaced by its successor' (Finnane 2003:26). The enduring availability of detention, an intervention that places 'a constraint on any conception of the fully human status of the subject', is used to explain overlaps between periods (Finnane 2003:27).

Finnane's exploration of continuities and ruptures in the government of the psychiatrically dis-ordered intersects with my analysis of the arts of care. My periodisation of care implies a linear history punctuated by ruptures productive of a psychiatric subjectivity that is congruent with a characteristic political rationality. Moreover, I contend that these regimes take place in specific arrangements of power that are ultimately productive of different understandings of the capacity for autonomy of the psychiatrically dis-ordered. While this story of movement from one subjectivity and political rationality to the next may be described as a tale of improvement and progress – the asylum emptied and superseded by the community, the submissive inmate body replaced by the educable patient and the empowered consumer – there are also discrepancies within and overlaps across the periods. My periodisation is contestable in the sense that there was more than one regime in effect at any time. The co-existence of different care regimes is ascribed to the unstable and fluctuating capacities attributed to the psychiatrically dis-ordered that may call into play the powers of detention and the powers of freedom and to institutional constraints that limit the possibilities for implementing policies of the day. Thus, my thesis also explores the emergence of subjectivities in each of the care regimes that do not conform to the 'ideal' or characteristic subjectivity of each care regime, for example, the patient body in the Herd Care era and the inmate in the Community Care era.

Herd Care, 1925-1958

Herd Care reflects an arrangement that was separate from community while at the same time creative of a closed 'community', that is, a mostly self-sufficient institutional setting that was segregated from the surrounding district. The term 'herd care' was used by Kenmore nurses to describe a certain style of care that structured and limited staff interactions with inmates and secondly, to denote the overcrowded conditions of the asylum that persisted into the 1960s. Thus, while I formally mark the end of Herd Care in 1958, with the introduction of new mental health laws, some of the herding techniques that dominated during this regime continued well into the Therapeutic Community era, during which asylum residency numbers slowly began to decline.

In his analysis of the role of institutions in warehousing 'retards' in the United States, Wolfensberger observes that 'retards' were regarded as animals or, at the most, as sub-humans because they were believed to be 'potentially assaultive, destructive, and lacking in self-direction and constructive purpose' (Wolfensberger 1975:8-9). The history of the care and accommodation of 'retards' and the psychiatrically dis-ordered is intertwined, and the constructed subjectivities of these cultural Others overlap, mainly through the frame of degeneracy. Wolfensberger's argument illuminates the rationale for the predominant mode of care at Kenmore Hospital during the period leading up to the late 1950s. There are parallels in the descriptions of the intellectually dis-abled and the psychiatrically dis-ordered, and these parallels explain similarities in their care.

Herd Care implies the management of groups of animals, and this tactic was reflected in daily ward routines. The imagery of animals and their management is also conveyed in Wolfensberger's writings on institutional models for retarded persons in twentieth century United States:

> (i)n 1901, an observer remarked that the retarded in a certain Midwestern institution were being herded like so many cattle (Clark, 1901). Sixty-eight years later, the residents were still being herded like cattle in the same institution in that cattle-oriented state. (Wolfensberger 1975:61)

Similarly, the early twentieth-century treatment regime at Brandon asylum in Manitoba is likened by Edginton 'to the management of a herd, because there was little attention given to the inmates' (Edginton 1988:182). And in New Zealand, Frame describes her experiences of asylum routines as follows: 'We stood there naked, packed tightly like cattle at the saleyards, and awaiting the random distribution of our clothes …' (1961:83-4).[5] The imagery associated with herd care era did not end in 1958. Forty years later, Kelley Johnson describes aspects of the organisational culture at Hilltop, an institution for intellectually disabled women in Australia, as follows: 'everything was done together like herding of cows' (Johnson 1998:35).

Herding inmates is a legacy from the nineteenth-century, a managerial tactic for coping with overcrowded and understaffed asylums. For example, Scull draws our attention to Bucknill's description in 1880, of 'industrial' asylums in the United Kingdom where staff would 'herd lunatics together' (Scull: 1980:50). The accumulation of society's failures in inadequately resourced asylums dictated the kind of response the inmate could expect to receive. In Kenmore, the Herd Care regime dominated in a period governed by a world war and economic recession, during which the funding of asylums was in steady decline. The post World War II period was marked by overcrowded conditions in institutions that had been allowed to stagnate in disrepair and despair.

Herd Care is a custodial regime of care. The NSW *Lunacy Act* 1898, which was in force until 1958, emphasised the restraint and confinement of inmates (Shea 1999). Under this *Act*, voluntary admissions were not available until an amendment was passed in 1934. While NSW asylums had informally admitted voluntary patients as early as 1845,[6] these were few in number. The two main forms of admission were by Order or by Request. Reports of the NSW Inspector-General of Mental Hospitals and my data for Canberra admissions to Kenmore suggest that, for the duration of its legal lifespan, two-thirds of admissions to asylum care under the *Lunacy Act* were typically on a Magistrate's Order and

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[5] I am grateful to Tony O'Brien for drawing my attention to Frame's comments.

[6] The first recorded voluntary patient in NSW was a male, William Leslie, who approached the Superintendent of Tarban Creek Asylum, renamed Gladesville Hospital for the Insane in 1869, and requested his own admission (Shea 1999:51).

about one-third of admissions were on Request. A Request removed the requirement of an open legal hearing. With reference to this admissions procedure, Commissioners of the 1923 Royal Commission on Lunacy Law and Administration in New South Wales observed that ‘the distressing features of police court proceedings are obviated. The painful publicity of the Magistrate’s Court is in many cases repugnant to the feelings of the relatives’ (quoted in Shea 1999:57). It was also noted that Requests were more popular in admissions to ‘private mental hospitals’ (Shea 1999:55).

The inmate was the typical subject and object of Herd Care. S/he was usually an involuntary admission, deemed incapable of exercising freedoms in a morally responsible and rational manner, and regarded as being in need of a disciplinary response. In the absence of effective pharmaceutical interventions, physical restraint and confinement were emphasised, reinforced by *locked door* policies. A docile, submissive and passive body was the ideal inmate.

Therapeutic Community, 1959-1982

Therapeutic Community symbolises a period when ‘the community’ – that is, the surrounding district - was invited into the asylum and an asylum network moved into the emerging mental health community. The precursors for this regime of care are attributed to a number of developments including the rise of social psychiatry after World War II that was influenced by the establishment of therapeutic community psychiatric facilities by Maxwell Jones in the 1940s, pharmaceutical advancements in the 1950s, and the proliferation of psy-professions from the 1960s onwards (Clark 1977:948; O’Brien 2001:129-137). In 1953, the Third Report of the Expert Committee on Mental Health of the World Health Organisation referred to the role of the psychiatric hospital as a therapeutic community, and urged ‘for activity and a proper working day for all patients’, the ‘preservation of the patient’s individuality’ and formal acknowledgement of their capacity for ‘responsibility and initiative’ (Clark 1965:949).

The 1960s was a decade of unrest, of civil rights movements including anti-psychiatry activism, given credence by writers such as Laing, Foucault, Goffman and Szasz. Policy and psychiatric literature argued for the return to community solutions, but whether reformers were motivated by political ideals or by economic considerations remains questionable (Laws and Dear 1988:84).

Reflecting on this historical period of mental health government, Hacking observes that:

> Local authorities and health services were beginning to be strapped for funds after the initial post-war boom, and in the late 1960s and 1970s were delighted to discover that it was politically incorrect to incarcerate fairly harmless mad people at public expense. (Hacking 2004:292)

The staff and residents of Kenmore Hospital were also affected by these governmental trends. The NSW *Mental Health Act* 1958 superseded the *Lunacy Act*, signifying a shift to the care regime I refer to as Therapeutic Community. The *Mental Health Act* shifted in emphasis from custodialism and restraint to medical treatment (Shea 1999:62; Wood 1979:26-27). It emphasised the desirability of voluntary admissions and created new categories of patients such as the temporary patient, with a more active review of lengths of stay.[7]

The Therapeutic Community approach is representative of a model of care that views the inmate as an individual ‘capable of growth, development, and learning’. It seeks to ‘foster individuality, dignity, privacy, and personal responsibility’ (Wolfensberger 1975:15). The Therapeutic Community care regime marked the expansion of a facilitative response by government towards the psychiatrically dis-ordered, with programs that actively prepared them for their reintegration into community. Pharmaceutical interventions were viewed as more effective and ideologically appropriate than physical restraints. *Open door* policies were introduced, giving a large percentage of patients an unprecedented greater freedom of movement. The patient was the typical subject and object of care. S/he was usually a voluntary admission, deemed to be temporarily incapable of exercising freedoms in a morally responsible and rational manner, but regarded as amenable to programs of rehabilitation, resocialisation and integration under the supervision of appropriately trained staff.

Community Care, 1983-

Community Care represents a period in which asylum knowledge and practice have been dispersed across a defined territorial jurisdiction, the multiple, heterogeneous sites of restoration and regulation known as the mental health community. The acceleration and proliferation of care in the community,

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[7] Shea writes that under this *Act* the concept of the voluntary patient, imbued with the competence to give informed consent was ‘frequently stretched beyond recognition’, describing the observations of an Independent Committee on ‘Total Patient Care in NSW Psychiatric Hospitals’ (1976) that found severely intellectually disabled ‘voluntary’ patients in three NSW psychiatric institutions (Shea 1999:63,72n).

particularly from the late 1970s onwards, is linked to neoliberal rationalities, including the turn towards market solutions for social problems and accompanied by a downturn in public spending by government in health and other services, thereby recasting 'the relationship between the individual and the state' (Pratt 1999:43; Vernon and Qureshi 2000:255). This shift in governance rests on the assumption that:

> Where once it was said that the greater part of humanity was not yet able to cope with demands of self-government, it now tends to insist that, given suitably conducive external conditions, we are all of us capable of autonomous conduct. … The discourse of improvement … now treats those who need improvement as if they were in fact autonomous agents. (Hindess 2002:34)

In 1983, recommendations of the *NSW Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* (the 'Richmond Report') provided a blueprint for accelerating the decentralisation and outsourcing of asylum services to non-government organisations and to psychiatric units of general hospitals. This process was described at the time as a program of 'rationalisation' (Richmond Report: 1983:8). The Inquiry was initiated partly by concerns about the ongoing treatment and care of the 'developmentally disabled' in asylum settings. However, the Richmond Report is now remembered more for its program of emptying and closing down asylums, part of an international trend referred to in the broader literature as deinstitutionalisation.

Community Care is a model of care that regards the mental health consumer as an individual with the capacity for self-care and self-responsibility.[8] The policy discourses of this care regime emphasise the worthiness of programs that enhance and support consumers' skills and abilities to live in the community, while its mental health laws reaffirm the tenets of Community Care. The ACT *Mental Health (Treatment and Care) Act* 1994 states that:

> In making a mental health order in respect of a person, the tribunal shall take into account: ...
> (h) that the person should be encouraged to look after himself or herself;
> (i) that, as far as possible, the person should live in the general community and join in community activities;
> (j) that any restrictions placed on the person should be the minimum necessary for the safe and effective care of the person; (p. 21)

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[8] The global changes that were to varying degrees experienced in Western nations from about the 1970s onwards, from centralised welfare models to decentralised, marketised models of governance, were preceded by the civil rights movement (Bunton 1998; Gordon 1987; Tully 1999). The voices of patient advocate groups questioned the medical authority in the unequal doctor-patient encounter. Thus, Tomes locates the rise in the use of the term 'consumer', generally associated with the growing popularity of market-place terminology, with patient activism of the 1960s and 1970s (Tomes 2006:84).

Reflecting the governmental emphasis on 'care in the community', this *Act* provides for Community Care as well as Psychiatric Treatment Orders. In addition to prescribing a range of treatment regimes, Community Care and Psychiatric Treatment Orders may require persons to reside in a specific facility or in the community and to be restricted from seeing certain persons.[9] Persons described as mentally dysfunctional may be subject to a Community Care Order. 'Mental dysfunction' is defined in the *Act* as 'a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion' (p. 3). Psychiatric Treatment Orders are for persons diagnosed with a 'psychiatric illness', defined in the *Act* as:

> a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms:
> (a) delusions;
> (b) hallucinations;
> (c) serious disorder of thought form;
> (d) a severe disturbance of mood;
> (e) sustained or repeated irrational behaviour indicating the presence of the symptoms referred to in paragraph (a), (b), (c) or (d). (p. 5)

The mental health consumer is the typical subject and object of Community Care. S/he is free to exercise responsibility and choice, empowered and autonomous, skilled in the arts of self-government, and living independently in the community.

Layout of the thesis

The thesis is divided into four sections. The first Section sets out the theoretical and methodological underpinnings of my thesis. Chapter 2 articulates a history of a mode of care that evolved in the asylum. In Chapter 3, I reflect on methodological issues from the field sites of the asylum and the community. The themes of these chapters underpin the premises of Chapter 4, where anthropological insights into research findings are used to illustrate my epistemological position on the limits of revealing the 'real' subjects of care and secondly, to consider why these subjects have been deemed in need of care.

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[9] Detention is still, however, mainly used in the context of the Psychiatric Treatment Order: a total of 10 Community Care Orders in the ACT were made in the year 2002- 2003 in comparison with 404 involuntary admissions to the public psychiatric facility (ACT Department of Justice & Community Safety 2003).

The remaining three sections are ordered thematically. Understandings of Herd Care, Therapeutic Community, and Community Care are developed by focusing on their environmental settings and the relationships and possibilities for action they give rise to. For despite their differences, I propose that the three care regimes share core principles that resemble the tenets of a 'care system' developed over 200 years ago. They each utilise techniques to develop morally and socially appropriate behaviour; they each articulate visions for a moral environment by drawing on representations of family and community; and each care regime acknowledges the importance of relationship between the care provider and care recipient.

In Section II, I describe the environmental settings for care. This Section examines the historical, legal ties that bound the asylum and community together. It traces the construction of Kenmore Hospital, the settlement and development of Canberra as the Nation's Capital, the formal governmental links established between the asylum and the community, and the planning of Canberra's community psychiatric services. The physical and spatial design features of each care regime are described. I consider how the spaces of Herd Care, Therapeutic Community and Community Care are productive of 'making up' the psychiatric subjectivities of the submissive inmate, the educable patient and the empowered consumer.

Section III focuses on the relations of care through an historical exploration of the dynamics of the care-provider and recipient encounter. It describes families' roles and responsibilities in the care of their relatives and explores how the metaphor of family shaped nursing practice in the asylum. Understandings of the different roles of care providers in each care regime are developed, firstly, by examining the shift from family to carer and, secondly, by describing the professionalisation and expansion of psychiatric nursing. The proposition that family symbolises both the cause of psychopathology and the source of cure is considered.

Section IV focuses on the subjects of care and explores why the residents of Kenmore and the consumers of Canberra have been deemed in need of care. It examines the kinds of behaviours and attitudes that marked them as cultural Others; and describes how the techniques of each care regime are productive of different possibilities for action. Integral to this analysis is a consideration of a dialogue between psychiatry and the concept of autonomy.

SECTION I

THEORY AND METHOD

2. The Arts of Care

> We are heirs of confinement, whatever we may think, and whatever may be suggested to us by the flattering imagination of rupture. (Gauchet and Swain 1999:268)

Gauchet and Swain are referring to the ‘modern spirit of confinement’ that coincided with the rise of the state apparatus, and contrasting it with the treatment of insanity in the Middle Ages, of banishment from the social. The notion of rupture alongside a belief in progress is a seductive proposition. However, while over time moral formations and expectations of sociality have changed, some of the assured narrative of social evolution and improvement may be questioned. The authors argue that the imposition of segregation in the institutional era, involving the recognition, acknowledgement and diagnosis of the person by state agencies of care, and the integration of difference through the creation of ‘another universe’ in lunatic asylums has been sustained in the supposedly post-institutional, community treatment era. For the imperative of homogeneity that originally demanded the exclusion of difference now similarly ‘commands the end of exclusion’ and the promotion of policy programs of integration within the community (Gauchet and Swain 1999:268). The modern management of difference, then, reproduces the arts of segregation and integration, ‘rejection’ and ‘insertion’ through an ongoing governmental concern of ‘conferring a social identity on the very beings whose social non-existence is being sanctioned and materialised’ (Gauchet and Swain 1999:269).

This chapter contends, firstly, that the lineage and logic for an Australian twentieth-century ‘care system’ may be traced to the eighteenth-century, to an ethos of care described as moral treatment (Borthwick, Holman, Kennard, McFetridge, Messruther, Wilkes 2001:427). While I acknowledge the analytical dangers of conflating ideas for the purpose of imagining ancestral linkages (Scull 2006:87), I also suggest there may also be merit in exploring ‘how uncannily similar present ideas can be to past practices’ (Dikötter 1998:478). Accordingly, I will explore the ways that key principles underpinning moral treatment – a care regime that emerged in mid to late eighteenth-century Europe – have persisted to the present, even if known by other names. Secondly, I argue that change has not necessarily been ‘progress’; rather, I propose that there is a core that is intrinsic to all care regimes. This core consists of answers to moral issues about when, why, how, and what arts may be applied to or by the psychiatrically dis-ordered.

Defining care

The project of care is an inherently moral task. In general, its objectives are to provide ease, comfort, guidance and support, and to attend to the physical, mental, moral, and emotional needs of legal minors, the aged, the sick and the disabled. These broad objectives are realised in heterogeneous environmental settings and draw on diverse language and practice.

Intrinsic to the arts of care are the interactions between the care-recipient and the paid or unpaid, formal or informal care-providers. The interpersonal relations between the care-provider and the care-recipient thus form the basis of the care encounter. Intentions to care and expectations of care are creative of a micro-politics of intertwined acts of beneficence and coercion, empowerment and restriction of freedom. Accordingly, a *duty of care*, implying both responsibility and moral authority, justifies actions that may protect and guide as well as punish and discipline the care-recipient. A duty of care may involve a disregard for the views of the care-recipient as much as it may demonstrate empathy and understanding. This is related to the specific and/or 'special' needs and vulnerabilities attributed to the care-recipient that render her or him in some way incomplete or inadequate, lacking in capacity or ability: 'we can coerce them into what is best for them, or in the interests of others' (O'Brien and Golding 2003:169,171).

The subject and object of care may respond to the intents and efforts of the care-giver from within a continuum of compliance and resistance. These dynamics are intrinsic to understanding the meanings of care, as irreconcilable and enduring as they are complex and flexible.

In the formal, governmental settings of the asylum and the mental health community, the concept of care evokes a range of techniques and terminology that overlap in meaning and practice. The arts of care may, for example, be aligned within the multidisciplinary scope of rehabilitation, which aims to 'maximise the participation of the patient in his or her social setting' (Wade and de Jong 2000:1386). Rehabilitative techniques include a mixture of mundane activities and problem solving, educational activities that are 'focused on a patient's behaviour', and involve assessment 'of the patient's problems' and the factors relevant to their resolution, goal setting, intervention, and evaluation (Wade and de Jong 2000:1386). My thesis chapters describe how the participation of the psychiatrically dis-ordered in rehabilitative activities has changed throughout the twentieth-century.

Care for the psychiatrically dis-ordered may also include a broad group of practices described as therapy. The objectives of therapy are similar to those of rehabilitation but suggestive of a greater ambition: of transformation, if not cure. The arts of therapy refer to prescribed, stylised activities that, by invocation of specialised bodies of knowledge overseen by a diverse range of psy- and allied health workers, render the acts or events sacred, at times transformative. Like the arts of rehabilitation, therapy appropriates the mundane activities of daily life within a technical paradigm. Bloor, McKeganey, and Fonkert write that the 'act of redefinition' – of the mundane into the sacred – 'is the motor of therapy' (Bloor *et al* 1988:6):

> We conceive of therapeutic work as cognitive activity which can transform any mundane event in the community by *redefining* that event in the light of some therapeutic paradigm; … To so redefine an everyday event as an occasion or a topic for therapy sets it apart and transforms it, much as the profane is transformed into the sacred by religious belief and ceremony; a simple act like cleaning the toilets or mending a leaking sink is invested with new meaning and held up as relevant to the cleaner's recovery or rehabilitation. (Bloor *et al* 1988:5, authors' emphasis)

An example of this understanding of therapy is the program of work developed by RD Laing and other psychiatric registrars during 1953-55 for the refractory inmates of Gartnavel Royal Mental Hospital. The most socially withdrawn inmates were selected to participate in activities at the Rumpus Room where they were encouraged to become involved in craft and domestic activities and social outings into town under the guidance and supervision of nursing staff. After a twelve month period, their progress was described as follows by Cameron, Laing and McGhie:

> They were no longer isolates. Their conduct became more social, and they undertook tasks which were of value in their small community. Their appearance and interest in themselves improved as they took a greater interest in those around them. These changes were satisfying to the staff. The patients lost many of the features of chronic psychoses: they were less violent to each other and the staff, they were less dissheveled, and their language ceased to be obscene. The nurses came to know the patients well, and spoke warmly of them. (Cameron *et al* 1955:1386, cited in Abrahamson 2007:207)

The Rumpus Room at Gartnavel Royal Mental Hospital was therapeutic not only because of the large array of activities it offered inmates under the supervision of nursing staff but also because it provided an environment conducive to recovery and cure. This Room is described as 'large, bright, newly decorated and comfortably furnished' (Abrahamson 2007:206). The notion of therapy, then, refers not only to an activity: therapeutic effects may also be induced by the inanimate, by the curative and transformative effects of buildings and grounds that, having been inscribed with psychiatric and/or moral architectural knowledge, imbue mundane environments with sacred configurations.

The potentially therapeutic role of the environment has a long and culturally diverse history that may be traced back to the era of Greek Aesculapian temples (Clark 1965:947; Biley 1996:111). The nineteenth-century lunatic asylum, designed not only to confine and control the insane, but to provide a sanctuary and a healing environment, is thus but one example of a purpose-built therapeutic milieu. The spaces of the asylum were regarded as therapeutic, non-medical treatments for recovery through their representation and mobilisation of the 'condition of cure', that is, by providing an *ordered geography* conducive to 'the permanent regulation of time, activities and actions, … which surrounds, penetrates, and works on bodies …' (Foucault 2006:2,3). The potential for therapy and rehabilitation was thus inscribed into the asylum landscape; the buildings and grounds of this form of 'moral architecture' increasingly designed through the collaborative efforts between psychiatry and architecture. In later years, the decline of the asylum was based on the rise of a discourse that disputed the asylum's therapeutic claims and contrasted 'asylum' with 'community', described as an 'open, benevolent, accepting and *therapeutic*' setting (Hazelton 1995[a]:159, emphasis added).

In addition to rehabilitation and therapy, care may also refer to a broad group of practices described as treatments. In her overview of public policy in Victoria from the 1940s to the 1990s, Robson associates treatment with 'clinical care' (Robson 2008:26). In the context of the asylum and the hospital, the term treatment has historically been used interchangeably with therapy and care.[10] The use of the term 'treatment' gives its practice the air of authority. At times, treatment has been used to denote stylised techniques for disciplining and restraining the lunatic body. In nineteenth century asylums, for example, the term 'medical treatment' was at times used to refer to 'a shower bath, usually a

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[10] Two examples of the linguistic flexibility of terms such as therapy and care in medical settings are standard descriptions of the effects of psychotropic medication in terms of levels of *therapeutic* compliance; and the use of the concept of care to encapsulate a summary description of the total patient experience in a hospital setting, as *good* care or *bad* care.

punishment for bad behaviour' (Scull 1979:202). The Weir Mitchell Treatment, popularised in the late nineteenth-century, is another example. It involved a prescribed diet, enforced rest through confinement and isolation, and the use of mechanical restraints such as straight jackets or camisoles.

As has been noted, the heterogeneous body of specialised and mundane techniques of care has broad application: care may refer to the mobilisation of treatments and therapies such as medication, electro-convulsive therapy, architectural design, rehabilitative activities, and mechanical restraints. Are there factors, then, that contribute to uniting these diverse and seemingly disparate terms and practices of care, that provide them with their logic and coherence? Questions regarding the logic that unite the arts of care are addressed in this thesis by focusing on its moral intents and effects. Indeed, I argue that the engine or driver of care is located in its moral ethos.

The 'care system' of moral treatment

The intents of care are guided by 'a moral orientation … an ethics … or a set of values' (Sevenhuijsen 2000:5). By moral/ity and ethics I refer to religious and/or secular norms, values and beliefs that inform why, when, how and where a duty of care should be enacted. The arts of care are thus shaped by the historically and socially specific moral orders in which they are formalised and performed. One of the most famous examples of the moral orientation and explication of care that continues to inform policy debates is the treatment regime developed by 'lay' reformers in the Retreat at the end of the eighteenth century (Borthwick *et al* 2001).

The moral treatment that was developed by York Quakers privileged the use of moral over medical techniques (Porter 1992:286).[11] The Retreat opened its doors in 1796. The Quaker establishment fused religious values into a 'care system' for the insane described as moral treatment, that was subsequently influential in shaping nineteenth century asylum reform in Europe and North America (Borthwick *et al* 2001:427; Tomes 1988:8). The Retreat was William Tuke's response to the poor conditions at the York Asylum that led to the death of

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[11] The 1828 Madhouse Act and the 1845 Lunatics Act determined that asylums employ the services of a medical practitioner (Porter 1997[a]:499; Scull 1979:163) and in 1836 a predominantly non-medical approach was shifted by the appointment – for the first time – of a resident physician (Scull 1979:162). While moral treatment was still regarded as an effective managerial response to difficult and unruly inmates; it was now formally subordinate to medical intervention.

the Quaker Hannah Mills in 1790. Tuke was motivated to 'provide a humane, homely environment for people "afflicted" by the "loss of reason"' (Borthwick *et al* 2001:427). The construction of the purpose-built institution was funded by Members of the Society of Friends. While the purpose of the Retreat was to provide care for Members in accordance with Quaker values, it also accepted non-Quaker patients from the first year of its operation but charged them double the rate (Stewart 1992:3, 25-26).

The origins of moral treatment were not exclusive to the work of reformers associated with the Retreat, but evolved in other care establishments in the second half of eighteenth-century Europe.[12] The French development of *traitement moral,* pioneered by Pinel at the Bicêtre and Salpêtriere hospitals, preceded the Retreat's work.[13] Indeed, Charland notes that Pinel's work informed Samuel Tuke's *Description of the Retreat* (1813). Not only did Tuke borrow the term 'moral treatment' but Pinel's influence is also found 'in the medical categories he uses to classify the various sorts of insanity that were treated at the Retreat' and 'in his attention to the more passional or affective dimensions of mental disorder' (Charland 2007:75). Due to its closer linguistic and cultural fit with the management of the mad in Great Britain and subsequently, its colonial outpost of Australia, my use of the term 'moral treatment' is influenced by the ethos of care most famously associated with the Retreat.[14]

Key characteristics of moral treatment include a 'controlled' environment that is aesthetically pleasing and calm, with family-like features, meaningful work and recreation activities for inmates under staff supervision and guidance, over which presides a benevolent, paternal medical superintendent (Borthwick *et al* 2001; Finnane 1981:201; Foucault 1964; Scull 1979; 1980:48). Edginton observes that moral treatment,

> in the context of the Retreat, focused on: (1) the realisation of the humanity of the insane or their incompleteness as rational individuals, (2) the need for non-medical or psychological aspects of treatment, (3) the treatment of the insane as children and the asylum organisation as a family, and (4) the use of nature as a means of calming insanity. (Edginton 1997:95)

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[12] Porter writes that the new ethos of care emerged in the second half of the eighteenth century but that the Retreat popularised it (Porter 1990:50). Scull has also observed that the Manchester Lunatic Asylum and an asylum in Bristol had begun developing 'mild management' techniques prior to the Retreat's construction (Scull 1981:106).

[13] The famous liberation of inmates by Dr Philippe Pinel commenced at Bicêtre in 1793. Pinel believed that 'the mad behaved like animals because that was how they were treated' (Porter 1997[a]:495).

[14] Charland notes the semantic differences between English and French meanings of the terms 'moral', 'emotion' and 'passion' (Charland 2007).

The Retreat provided care for the insane in a therapeutic environment originally built to accommodate approximately 30 patients (Scull 1980:46), with architectural features designed to effect their recovery and cure. The design principles of its moral architecture influenced the construction of purpose-built asylums throughout the nineteenth-century (Edginton 1997:95; Scull 1980:43-45).

The goal of moral treatment was to provide 'mild, humane treatment without restraints' to encourage and 'direct' the insane towards responsibility and self-discipline, key Quaker habits and values, through the principles of kindness and respect (Edginton 1997:95; Finnane 1981:201; Stewart 1992:2). The aims of moral treatment were more ambitious than merely to provide ease, comfort, and support for the dis-ordered body. It 'sought to *transform* the lunatic' (Scull 1981:111). Moral treatment, then, was a form of therapy that sought transformation and cure, its motor embedded within the art of redefining the mundane into the sacred in a morally supportive setting.

Historians have noted that moral treatment was based on an understanding of insanity that emphasised a 'mental rather than a somatic aetiology' (Scull 1979:159), the 'rational and emotional rather than the organic causes' (Digby 1985:53). The inner logic of moral treatment was thus founded on the emerging belief that the insane suffered an impaired rather than a total loss of reason. The aetiology of madness slowly shifted from 'punishment from God, devil's work, to secular terms, related to the mind' (Lis and Soly 1996:24). This shift encouraged the development of different kinds of treatment, from 'external coercion' to the use of techniques that sought the 'internalisation of moral standards' within the insane (Scull 1981:111).

Charland, however, locates the key to understanding the pragmatics of moral treatment not so much in the loss of reason or mental capacities of the insane, but on their capacity to 'experience and exercise benevolence' at a 'primitive' level:

> Moral treatment at the Retreat was premised on the observation that core benevolent affections in humans remain mostly untouched by madness. … It was a therapy of the passions that worked through the passions. Reason had little to do with it. This was not primarily a "talking" therapy like our modern cognitive psychotherapies. It was a primitive form of affective conditioning with benevolence at its core. (Charland 2007:68-69)

According to Charland, moral treatment worked through both ethical *and* affective capacities of the insane (Charland 2007:78). He writes that the Quaker belief in the Inner Light of God resident in each human being 'is the main reason why they believed that the mad were still human despite their condition … Not even madness could extinguish that light.' Charland adds that the notion of a universal Inner Light overlapped with popularised understandings of benevolence at the time, in particular Hutcheson's 'doctrine of benevolence' that accorded with Quaker values of 'benevolence, charity, discipline, self-restraint, temperance' (Charland 2007:70).

Charland's writings contribute an understanding of how moral treatment worked on and through the body, mind and *passions*. To what extent these points of *entry* can be distinguished from one another (let alone how they are ordered within the pragmatics of moral treatment) is a tricky question, for the reality of body, mind and *passions* depends on the cultural situatedness of the observer. Despite these questions, his writings are a useful reminder that the engine of care is holistic in approach – working on a range of levels - and complex in method.

In contrast to Charland's emphasis on the benevolent face of moral treatment, Godlee provides a more instrumental understanding, reminding us that the use of 'kindness and humanity',

> was not the aim of moral therapy, only the intended nature of its administration. The aim of moral therapy was to achieve a degree of social conformity in the insane as a means of non-violent management and in order to reclaim them, if possible, for society. (Godlee 1985:76)

Godlee's argument is insightful, particularly when one appraises the evolution of moral treatment in the large, underresourced and understaffed asylums of the nineteenth century, when it was subverted into a form of 'moral management', a shift referred to by Samuel Tuke, grandson of William Tuke, in his *Description of The Retreat* as follows:

> humane and individualistic aspects disappeared, and emphasis was placed instead upon the latent strength of moral therapy as a socially acceptable mechanism of enforcing conformity. (Tuke, quoted in Stewart 1992:5)

While the emphasis on regulation and discipline may not have been the main intention of lay reformers at the Retreat, Scull observes that 'the potential for its transformation into an instrument of repression was always latent in moral treatment' (Scull 1979:209) for,

> (e)mbedded within moral treatment from the outset were structural tensions between repression and rehabilitation, between the imposition of moral discipline and the development of self-government and self-control. (Scull 1993:14)

In this way, the asylum arts of custodialism and therapy 'were not always separate, nor always predictable' (McGovern 1986:16). This tension has also been described in terms of a Janus-faced relationship (Digby 1985:60): although it may be equated with mild and humane care, the other side of moral treatment also included the application of coercive tactics, including restraint, whether to protect the insane or to protect others from them, or to encourage them to develop self-restraint and compliance with social norms (Sammet 2007:295). By coercion I refer to the use of physical 'force, but also acts of manipulation and persuasion that do not involve overt force' such as, for example, 'under-disclosure', and 'restricting possible choices' (O'Brien and Golding 2003:169). Alongside the promotion of kindness and restoration, then, there was always the promise of persuasion and restriction of choices. Moral treatment was thus a complex of intertwined acts of beneficence and coercion, empowerment and restriction of freedom.

The restorative and regulative promises of moral treatment gave rise to interventions that were deemed suitable for the emerging subjectivity of the insane. Porter notes that if the insane 'are seen as animal … discipline and coercion will probably be the dominant or sole methods of treatment' (Porter 1985[a]:1). He observes that '(b)y the end of the eighteenth century the lunatic was beginning to be seen less as brute than as human' (Porter 1985[a]1). Whippings and beatings to ensure bodily compliance were slowly superseded by techniques that worked on the mind. These shifts in practice heralded a 'new ethic of rehabilitation' whereby the 'madman' was not only imbued with new capacities but was also expected to develop self-control, leading to 'the recognition that he alone was responsible for the punishment which he received' (Scull 1981:115).

The arts of self-government were gradually fashioned into an invisible cloak of responsibility:

> The obscure guilt that once linked transgression and unreason is thus shifted; the madman, as a human being originally endowed with reason, is no longer guilty of being mad; but the madman, as a madman, and in the interior of that disease of which is no longer guilty, must feel morally responsible for everything within him that may disturb morality and society, and must hold no one but himself responsible for the punishment he receives. The assignation of guilt … becomes both the concrete form of coexistence of each madman with his keeper and the form of awareness that the madman must have of his own madness. (Foucault 1964:234)

Deviations from self-restraint were liable to a disciplinary response as part of a 'system of rewards and punishments' (Tomes 1988:7), to remind the insane of their responsibility, to heighten fears of future transgression, and to encourage compliance within the therapeutic moral order of the asylum (Foucault 1964:234-235).

Foucault relates a story told by Samuel Tuke of the reception of a young man diagnosed with mania. Upon arrival at the Retreat, all mechanical restraints were removed from his body and the newly arrived man was told by his keeper:

> that the entire house was organised in terms of the greatest liberty and the greatest comfort for all, and that he would not be subject to any constraint *so long as* he did nothing against the rules of the house or the general principles of human morality. (Foucault 1964:233, emphasis added)

While the insane could now anticipate the removal of physical shackles, such as the famous *liberation* of inmates by Pinel at the Bicêtre in 1792, their freedom was contingent upon adherence to behaviour that was subject to the surveillance, evaluation and correction by asylum keepers. Foucault describes the techniques of moral treatment as a trade-off of 'the free terror of madness (for) the stifling anguish of responsibility' (Foucault 1964:234).

Charland believes that Foucault has 'cast the role of fear and discipline in moral treatment in a cynical light' whereas, he argues,

> (w)hen used judiciously, fear can be an important instrument in the education of the passions generally, and the instruction of discipline and respect. There is therefore a plausible philosophical case to be made in defence of the use of fear and discipline in moral treatment (Charland 2007:73).

At the same time, Charland acknowledges that '(t)oo much fear, or too much discipline, and moral treatment is bound to fail' (Charland 2007:73). I would suggest that the judicious use of fear is not easily determined, for the boundaries between rehabilitation and repression are not clear-cut. Rather, they are flexible and opaque, and subject to competing interpretations.

By the 1820s, moral treatment had begun to be promoted by British lunacy reformers (Scull 1979:142), its ideas and practices mutating and evolving into a dominant discourse of governance that was subsequently systematised within practice in purpose-built asylums. Under the influence of state run, large-scale institutions for the insane, a managerial approach emerged that subverted the Quaker ideals of a homely environment and kindly supervision. Scull describes the growth of 'a highly rationalised, centrally administered and directed social control apparatus' in England (Scull 1979:19), while Lis and Soly note the development of a bureaucratic form of care in European asylums, involving the routinisation 'of activities, rigorous timetables, silence, the treadmill of regulations' (Lis and Soly 1996:189). The tensions between repression and rehabilitation that were embedded within moral treatment ‘were systematically resolved in one direction only, in favour of an oppressive system of moral management, enforced conformity, and disciplined subordination’ (Scull 1992:11).

The dynamics of care

In 1953, the World Health Organisation recommended best practice principles for the care and treatment of psychiatric hospital patients. These included:

1. Preservation of the patient’s individuality
2. The assumption that patients are trustworthy
3. That good behaviour must be encouraged
4. That patients must be assumed to retain the capacity for a considerable degree of responsibility and initiative
5. The need for activity and a proper working day for all patients
   (Clark 1965:949)

These principles were developed in accordance with a therapeutic community approach. In defining the attributes of twentieth-century care techniques of therapeutic community, some writers have acknowledged similarities in practice between early nineteenth-century moral treatment at the Retreat and the practices of some ‘modern hospital communities’ (Bloor *et al* 1988; Castel, Castel and Lovell 1982). However, while conceding these similarities, Bloor *et al* dismiss any historical connection between the two care approaches because, they argue, there was no continuity of practice and Tuke’s work was ‘largely forgotten’ while the asylums ‘entered on their long custodial sleep’ (Bloor *et al* 1988:18-19). Other writers, reinforcing this argument of discontinuity, attribute the demise of moral treatment to biological reductionism. They propose that when the discourses of biological aetiology and treatment dominate, non-medical solutions are not viewed as effective and are accordingly undervalued (Appelbaum *et al* 1985:11; Lewis 1988:123; Westmore 2002).

In contrast to the above perspective, Castel *et al* describe the broad system of ‘rewards’ and ‘punishments’ of therapeutic community, which aim to encourage self-restraint in the psychiatrically afflicted, as a reinvention of ‘the old principles of moral treatment’ (Castel *et al* 1982:193-195). Similarly, my examination of the arts of care is open to various specifications of technique as I am concerned with questions about the moral intents that drive the technique and about the specific governmental formations, knowledges, and practices that give rise to these intents.

While continuity of a consciously transmitted doctrine of moral treatment over time may not be attested by articulated rationales, it is possible to argue that the key principles underpinning moral treatment have mutated and evolved under different conditions and in different settings, over time and across spatial boundaries through the dispersal of methods, the creation and extension of professional networks, and their adaptation in different social and institutional settings (Crowther and Dupree 2006).[15] Furthermore, I question the use of new language to disguise 'old wine in new bottles' to eliminate 'the "baggage" and reputation that came with the previous name' (Ward and Maruna 2007:5-6), and suggest that the ongoing production of new discourses to describe similar theories and practices fuels the illusion of progress through breaks with the past (Cohen 1985, cited in Ward and Maruna 2007:6). In the chapters that follow then, terms such as 'moral treatment' and 'therapy' are specified when they refer to a particular socio-historical location. At other times, for analytical purposes, these terms are subsumed within an overarching exposition of the 'arts of care', separated out only through the parallel process for describing their periodisation. This tactic is used to question and unsettle taken-for-granted assumptions about linearity and progress.

One of the more common reasons for contesting the presence of moral treatment in the twentieth-century relates to the misapprehension that this care system utilises only the arts of rehabilitation and restoration. Some writers tend to see evidence of the 'echoes of the 200-year-old precepts of moral treatment' only when they can observe a rehabilitative focus (Appelbaum *et al* 1985:14). Similarly, Borthwick *et al* privilege restorative intents in their identification of seven principles of moral treatment that they believe are relevant to 'contemporary mental health care'. These include:

1. A concern for the human rights of people with severe and disabling mental health problems
2. Personal respect for people with severe mental health problems
3. An emphasis on the healing power of everyday relationships
4. The importance of useful occupation
5. Emphasis on the social and physical environment
6. A common sense approach rather than reliance on technology or ideology
7. A spiritual perspective (Borthwick *et al* 2001:431)

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[15] My use of the concept of mutation to explain and argue for patterns of continuity in the principles underpinning moral treatment evolved out of a paper presentation by Anne Crowther on the spread of Listerism across the British Empire, at the Australian and New Zealand Society of the History of Medicine Conference, Auckland, New Zealand, February 2005.

Against this view, I argue that the arts of moral treatment have always included a complex of intertwined acts of beneficence and coercion, empowerment and restriction of freedom. In contrast to those writers who overlook or ignore the repressive possibilities and promises of moral treatment, I do not disassociate these coercive practices from the arts of care. Nor do I propose that the distinction between repression and rehabilitation is always self-evident, for at the very least, production of a rehabilitated or restored self entails self-government. This stance is reinforced by my understanding of the relationship between freedom and power.

In the study of Western liberal societies, 'freedom' emerges as a central discourse of government. My study of twentieth-century Australian care regimes is interested in exploring the ways in which government manages the freedom of subjects by seeking, firstly, to act upon them 'through administrative, bureaucratic, and institutional channels' (Wolfe 2000:40) and secondly, to encourage them to be active in their own self-government. I focus on 'freedom' as a set of practices, 'a technical condition of rational government rather than the organising value of a utopian dream' (Burchell 1996:271). By freedom, then, I draw on an understanding that associates the term with the 'material, technical, practical, governmental' (Rose 1999:63).

Drawing on a Foucaultian approach, I apprehend power as dispersed across multiple sites and through a series of 'relays, networks, reciprocal supports, differences of potential, discrepancies' (Foucault 2006:4; Michael 2004:114). My genealogy of care thus considers how historical configurations of physical and social landscapes, care providers and recipients are in dialogue with and productive of shifting relays and networks of power. Twentieth-century care regimes, I argue, may be differentiated by shifts throughout these dispersed relays and networks of power that give rise to 'new ways for people to be' (Hacking 1986:223). Like Hacking, I am interested in comparing and contrasting modes of government in particular periods of history (Hacking 1986:225), and exploring his hypothesis that,

> (i)f new modes of description come into being, new possibilities for action come into being in consequence. (Hacking 1986:231)

Hacking's analytical approach has some intellectual lineage with the Chicago School of sociology in the 1950s and 1960s (Hacking 2004:290-291). More specifically, though, it is the work of Goffman and Foucault that has been influential in developing his theory on the constitution of personhood (Hacking 2004:278). Hacking's approach differs in that, rather than confining his study to either broad governmental change or to the micro techniques for 'making up people', he synthesises the two analytical approaches by using a 'looping effect'; that is, he explores the

> interactions between classifications of people and the people classified … the ways in which those who are classified, and who are altered by being so classified, also change in ways that causes systems of classification [to] be modified in turn. …. Classifying changes people, but the changed people cause classifications themselves to be redrawn. (Hacking 2004:279)

Hacking's looping effect is able to negotiate the tensions between structure and agency while at the same time provide an account of change. His approach has provided guidance in the analysis of my fieldwork data. It has informed my argument that the arts of care, subjectivity and the possibilities for action are interconnected and cyclical. And it has provided insights into how asylum and community techniques of care 'make up people' such as the inmate, the patient, and the consumer, the 'depressive', the 'schizophrenic', and the 'borderline', while at the same time remain subject to contestation and subversion.

Secondly, I consider power as 'physical, and there is a direct connection between the body and political power' (Foucault 2006:14). The arts of care are thus experienced by the psychiatrically dis-ordered as visible and overt, immediate, intimate and constraining, for example, being held down by ward *henchmen* while getting injected in the buttocks, being strip searched and/or undergoing a public shower/bath as part of admissions rituals, being placed in a seclusion room for answering back to a nurse.

Power that is 'not permeated by violence' is still a form of power, Foucault reminds us, for 'what is essential in all power is that ultimately its point of application is always the body' (Foucault 2006:14). The arts of care are thus also experienced as facilitative and productive of new forms of personhood by virtue of educative programs of self-care and self-governance packaged within a discourse of empowerment. Rather than viewing the body as a passive receptacle of power, though, the provision of care encompasses a dialectic of resistance, reproduction and subversion by agents and subjects of government that transcend body/mind distinctions.

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This chapter described how the arts of care represent an enduring governmental need to confer identity on the psychiatrically dis-ordered in order to manage them better, and proposed that the history of the arts of care reveals a legacy and lineage of continuity as well as rupture. I proposed that while the terms used to describe care have overlapping intents and they each may mobilise different techniques of repression and rehabilitation, they are united by their objectives and driven by a moral ethos. In the next chapter I reflect on how fieldwork shaped my analysis and periodisation of care.

3. Notes from the Asylum and the Community

The understandings of care that are developed in this thesis, including my periodisation of care, are informed by data accumulated in the course of 22 months' research in two field sites. My approach to the process of data collection was informed by an anthropological methodology: while my thesis explores the arts of care over a period of 79 years, the data used as evidence to support my analysis are not only historical documents that were accessible in archival institutions; data was also collected in the course of fieldwork as participant observer in both an asylum and a mental health community. This involved my taking on a myriad of roles, some that I was able to determine, and others that were selected for me by my informants. In the course of fieldwork, then, I participated as a resident researcher in an asylum, a volunteer in the asylum's museum, a board member for a mental health organisation and an advocacy group for women, and a member of a working group tasked with the establishment of a peak mental health body. These roles gave me access to other committees where I held observer and, at times, representative status. During this period, I also conducted interviews and group discussions.[16] My ethnographic encounters with the asylum and the community have thus profoundly shaped my approach to describing and explaining the arts of care and this chapter narrates some of the insights generated by my different fieldwork roles and their contribution to the main analytical framework of my thesis, that is, my periodisation of the arts of care.

My thesis is based on two kinds of data: the medical files of Kenmore Hospital, New South Wales (NSW) from 1925 to 1958, including Admissions Registers, Inebriates Registers and Medical Journals, and case notes up to the end of the 1951 financial year,[17] and participant observation, including 47 interviews

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[16] In general, group discussions tended to be taped while interviews were recorded by note-taking: individuals were more self-conscious about having personal accounts recorded on tape whereas in the group setting, research participants were comfortable with and appeared to enjoy discussions on their group's collective history. This has affected the extent to which I was able to collect information in the vernacular in the interview setting.

[17] The administration of inmates, patients and consumers is structured by financial rather than calendar years. The primacy of the financial ordering scheme in medical administrative ledgers remained a poignant and unsavoury reminder, throughout the course of fieldwork, of the reduction – the depersonalisation and dehumanisation - of psychological distress and disability into administrative priorities and statistical variables. My unease about this ordering scheme of time was exacerbated by a growing awareness of a history of underfunded and underresourced treatment and care services for an undervalued and dispensable population group.

with consumers, carers and community sector workers in Canberra, the Australian Capital Territory (ACT) 2002-2004.[18] In addition, I have drawn on: transcripts of interviews and group discussions with 15 former nursing staff and/or family members associated with Kenmore from 1940s onwards, their experiences spanning almost six decades; my participant observation as a volunteer at Kenmore's Hospital Museum; government reports for NSW asylums covering the period 1929-1987; and ACT policy documents from the 1960s until 2003.[19]

The data from the Admissions Registers included: age, marital status, nativity, religion, legal status, diagnosis, causes of insanity, and date of discharge. Because I was interested in the history of the servicing of the Canberra community, I confined my research using individual case notes to Canberra inmates. Admissions Registers entries recorded that 69 Canberra inmates had been admitted to Kenmore up until 1951, the first inmate arriving in the financial year 1925-26. At a later stage of fieldwork, due to my growing awareness of the gendered experiences of discipline and freedom, I sought and was given permission to access the Medical Journal, which commenced in 1895, the year Kenmore Hospital became operational, and ceased in 1959.[20] The Medical Journal represents a formal artefact of legal and administrative asylum accountability, subject to regular inspection by the Inspector-General of Mental Hospitals and Official Visitors. It set out, on a weekly basis, details of who had been put under restraint or seclusion and for what reason, the names of residents who had escaped, sustained injury or had died, and numbers 'Under Medical Treatment'. It formed the source of my database of aggregate figures on escapes and the use of mechanical restraints in the asylum over a 34 year period.

Methodological reflections from the asylum

My fieldwork in Kenmore was a privileged experience, in that I was the first researcher to access its medical records and secondly, that this access involved

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[18] In response to a consistently negative perspective towards Canberra's only formal psychiatric *lock up* facility from workers, carers and consumers, I sought and was given access to interview psychiatric nurses of the Psychiatric Services Unit (PSU). A notice outlining my research project and contact details was forwarded to nurses by the Unit Manager. Only one person responded to my request for an interview. A nursing perspective of Community Care is therefore not available and reference to the care techniques of PSU is based mainly on the experiences of psychiatric survivors, community workers and carers.

[19] Kenmore's residents and Canberra's research participants have been given pseudonyms.

[20] This is related to the implementation of the NSW *Mental Health Act* 1958 which superseded the NSW *Lunacy Act* 1898.

spending extended periods of time in the asylum's buildings and grounds.[21] Such unprecedented access to medical records in the asylum where they were created will no longer be available to future researchers of Kenmore's history: the records have subsequently been sent to NSW State Records. My find, rich data in medical files unsullied by the finger prints of previous researchers' forays into the past, was a fieldworker's fantasy come true. The data that was available to me in Kenmore also overwhelmed my original thesis proposal, giving the asylum a dominant role and basis for my investigation of the arts of twentieth century care that I had not and could not have anticipated.

When I arrived, medical files were still damp after their relatively recent discovery in a basement, and ledgers were spread out in a haphazard fashion throughout one room of the ward. Fan heaters were run every day to sustain the drying process. I wore cotton gloves and a face mask to protect my airways from mould spores. On each occasion of my arrival, a staff member working in the administration building would come and unlock the ward for me. After she left, the outside door to the ward remained unlocked. However, it was suggested I lock the inner door because, I was told, some patients might wander in. It was not explained why this might be a problem and I did not question her advice. There were approximately 50 patients still living at Kenmore, psycho-geriatric and minimum security forensic patients. During my role as researcher I never encountered any curious patients, but on several occasions the ward was surrounded by a herd of sheep passing though.

The silence of conducting research in a ward which at one stage accommodated approximately 100 patients was a rather eerie experience. The ward that housed Kenmore's medical records, where I worked on my own, was in disrepair, paint peeling off walls, an unsightly layer of dirt and the accumulated bodies of dead insects and faecal droppings of mice and rats on dislodged pieces of cracked linoleum, stained and dirty carpets. I experienced Kenmore through a range of senses that combined to form an embodied appreciation of the downfall and disgrace of this governmental solution for madness, witnessed through the neglect, disrepair and abandonment of many of the asylum's buildings and grounds. Some of the other buildings had also started to 'crumble';

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[21] Through fieldwork, I developed an appreciation of the environmental settings of the asylum that inspired me to expand my emerging geographical sensibility to the analysis of the field sites of Canberra's mental health community.

Plate 2: Kenmore Hospital 2005 Photo: D Kordes

Plate 3: Matron’s residence, Kenmore Hospital 2005 Photo: D Kordes

Plate 3: Matron’s residence, Kenmore Hospital 2005 Photo: D Kordes

Plate 4: Airing court, Kenmore Hospital 2005 Photo: D Kordes

Plate 5: Outside the matron’s residence, Kenmore Hospital 2005 Photo: D Kordes

Kenmore's state of disrepair reminded me of Cornish's account of St Lawrence Hospital in the United Kingdom, where 'the one-time congested buildings now stand hauntingly silent as empty shells, ... idle and decaying' (Cornish 1997:104, 109). During the course of my fieldwork at Kenmore, its buildings and grounds were sold to a consortium of developers and currently their future remains unknown.[22]

Soon after commencing research I discovered that Kenmore's medical records provided partial and inconsistently recorded accounts of inmates' experiences, mirroring the findings of Risse and Warner:

> Some accounts are detailed and organised, others flippant and casual, while progress notes were often neglected, abbreviated, or even invented. More important, one cannot assume that the actions specified in such records were consistently executed and represent all of the events experienced by patients and perceived by medical personnel. (Risse and Warner 1992:204)

In her doctoral thesis on 'good and mad women', Matthews interprets the 'truncated and often cryptographic' characteristics of case notes as records of institutional 'justification, … the defence against accusations of improper practice' (Matthews 1979:10). The quality or otherwise of records may also be reflective of institutional time constraints, staffing numbers and attitudes to record keeping (Garfinkel 1974):

> Patient records vary a great deal in both length and content, depending on individual professional prejudices and the social circumstances surrounding their composition. … The frequency of progress notes depended both on the patient's condition and the availability of transcription personnel. (Risse and Warner 1992:185,186)

It was not my intention to incorporate incomplete, partial and inconsistently recorded clinical notes within my analytical framework as if they formed an 'actuarial document … of completeness, clarity, credibility, and the like' (Garfinkel 1974:113). I was also aware of the methodological 'troubles' described by Garfinkel, from attempting 'to answer questions that depart in theoretical or practical import from organisationally relevant purposes and routines under the auspices of which the contents of the files are routinely assembled in the first place' (Garfinkel 1974:114).

At the same time, however, I also concurred with Risse and Warner, that the medical records might offer insights into 'the interaction between physicians and their patients in which individual personality, cultural assumptions, social status,

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[22] The keys to these buildings were handed over to the new owners in May 2005.

bureaucratic expediency, and the reality of power relationships are expressed' (Risse and Warner 1992:189).

Some of the case notes were difficult to decipher. Unlike the data generated by group discussions and interviews that are conducted by the researcher, medical records are not open to a dialogue. This made the process of decoding staff comments problematic, and at times I had more questions than the records answered. Were they indicative of empathy or humour as well as of psychiatric evaluation? In the case of Alison Jefferies, was the comment regarding her political views used to provide an objective example of her insanity or was it an example of staff humour?

> (e)xpresses intense sympathy for the working classes – says that treatment of the workers today is so dreadful that it is only to kill them off.

For Maggie Turner's admission, staff found it noteworthy to record her refusal to speak to the asylum doctor: 'it's no use speaking to you: you're not normal or you wouldn't be here'. While these comments tantalise the reader's imagination, the importance attached to recording them on file is not self-evident.

The insights of Erving Goffman on the role of case notes may provide a useful explanation for understanding why Jefferies' and Turner's remarks were recorded during their admission to Kenmore. As noted in the previous chapter, the centrality accorded to observation and description of psychopathology forms the empirical cornerstone of psychiatric knowledge. Case notes are material artefacts of these observations and descriptions, and may be used to express psychiatry's mandate 'to deal with the "whole" person'. Asylum staff had 'no limits to what they consider relevant' (Goffman 1961:144). Furthermore, as part of the admissions ritual:

> there is a special need to obtain initial cooperativeness from the recruit. Staff often feel that a recruit's readiness to be appropriately deferential in his initial face-to-face encounters with them is a sign that he will take the role of the routinely pliant inmate. .... an inmate who shows defiance receives immediate visible punishment. (Goffman 1961:26)

Drawing on Goffman's frame of reference, it appears that Jefferies and Turner had signalled their potential to become defiant asylum residents. The notations on their files were therefore not necessarily indicative of staff empathy or humour. Rather, their notes may have been intended to flag Jefferies' and Turner's potential for difficult and uncooperative behaviour. And certainly, after admission procedures for Jefferies and Turner had been finalised, their files were filled with notes that recorded each woman's unruly behaviour. Jefferies was consistently described as untrustworthy and dangerous; for example: '(a) very dangerous potentially homicidal woman. In camisole always. Cannot be trusted out of a camisole'; while Turner was portrayed as 'resistive and troublesome.

Case notes also justified residents' detention by making recourse to a discourse that constructed them as cultural Others, thereby setting out 'why it was right to commit him and is right currently to keep him committed' (Goffman 1961:144). Inmates' files thus also served to chronicle their transgressions:

> Occasions when he acted in a way which the layman would consider immoral, sexually perverted, weak-willed, childish, ill-considered, impulsive, and crazy may be described. Misbehaviours which someone saw as the last straw, as cause for immediate action, are likely to be reported in detail. (Goffman 1961:144.)

The observational and record-keeping techniques used by Kenmore provide insights into how its residents were regarded as cultural Others, through the use of a language that positioned them in opposition to the norms of rationality, industry and autonomy. Noteworthy manifestations of inmate language and behaviour were described by recourse to a psychiatry that had subsumed notions of primitivism and degeneration within its epistemological foundations. Staff drew on a language that situated inmates in this psychiatric field of knowledge, where attitudes and behaviours were observed and recorded on their case notes. The first Canberra inmate to arrive in Kenmore in 1925-26, Nora Shannon, is thus described as 'innocent look but not to be trusted', 'sudden violent attacks, unpredictability, dangerousness', 'evil'. Ivan Antoniak's notes describe him as 'dull and stupid', 'idle and apathetic'; Geoffrey Riley 'uses bad language, or laughs sarcastically at the Medical Practitioner', 'does no work – too mischievous', 'is untidy in dress – frequ. (sic) has his shirt outside his trousers'; Christine Lacey 'a typical epileptic – quarrelsome and irritable', 'violent and restless'.

Staff descriptions of their unruly charges not only served to justify custodial care. Any changes were noted and variably interpreted as demonstration of further manifestation of their insanity and/or degeneracy, or as signs of their recovery. Some staff recorded these nuances and changes on the 'Behaviour and Treatment Record' (BTR) form. Some of the categories of behaviour listed on the BTR include the following: Hilarious, Suspicious, Delusions, Resistive, Hallucinations, Impulsive, Suicidal, Aggressive, Destructive, Habits, Perverted, Confused, Dull, Stuperose, Refuses Food, Agitated, In Bed, Idle, Mute, Incoherent, Afraid. The BTR provided asylum staff with the opportunity for compiling a profile of the inmate over time and at the same time chronicling prescribed treatments. The form set out a spectrum of behaviours to choose from. Asylum staff, however, preferred to record their observations on Progress Notes. The BTR is interesting, though, in how it provided staff a check-list of the signs of defective otherness and linked these signs to a treatment response.

The incomplete and inconsistently recorded condition of the medical files raised many questions about inmate care and treatment, the answers for which I could only speculate upon. For example, the Medical Journal entries for restraints (and escapes) raised my awareness of the different treatments experienced by female and male inmates. Case notes provided only partial answers for why inmates received such differential care. At times, the medical records raised more questions than they answered. I was also conscious of the methodological shortcomings of relying upon only one source of data into Kenmore's history and made the decision to seek out another repository of knowledge to enhance my understanding of the inmate experience. I decided that at least some of the questions raised by the medical records could be addressed if I were to gain access to the record keepers, the former staff of Kenmore. This field of research inquiry could also provide a form of triangulation for my growing database of Kenmore's history. Furthermore, staff might be able to describe some of the informal practices (Garfinkel 1974:116) not recorded on the medical files. As three-quarters of the 'Friends' of the Kenmore Hospital Museum, situated in the former male Epileptic Ward, were former nursing staff of the asylum (total membership at the time was 99), I applied to become a Friend.[23]

As part of my induction to this new role, I volunteered to participate in a working bee for an exhibition commemorating Kenmore's sporting history. On the first day I arrived at the Museum I noticed how sporting memorabilia were displayed on various pieces of furniture, in particular over the beds of former residents. In my ignorance, I assumed that the memorabilia belonged to former residents and that this exhibition was grounded in patient history. Why else would sporting trophies, etc have been placed on their beds? I discovered that the trophies, banners and other sporting awards belonged to former staff and that the beds were regarded as little more than items of furniture on which they could be displayed. As a newcomer to this subculture, I was disturbed by the display of

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[23] My involvement with the Museum continued throughout this period and remains ongoing.

staff achievements on the beds of former residents. However, while my views about the patient perspective did not change, over time I also learned to respect the energy and commitment of Friends to the Museum, and their right to interpret Kenmore in accordance with their own situatedness that privileged the memories and perspectives of nursing staff.[24]

My role with the Kenmore Hospital Museum gave me opportunities for interaction, not only with former nursing staff, but with visitors, including members of the community, tourists, representatives of the psy-profession, and psychiatric survivors. While the irony of my role was not lost on me, welcoming visitors to the spaces of the former male Epileptic ward, it also provided me with opportunities to meet and listen to those who were keen to chat about their encounters with madness, as staff and as patient, and to hear their views of the asylum solution. Working with other volunteers in sweltering conditions while sweeping and mopping up possum urine and faeces around the closely spaced beds on the top floor on hot summer days, and barely managing to keep warm while clothed in jackets and boots in the downstairs dormitory on cold winter days, also provided partial insights into the physical living conditions for former residents.

In my role as Museum friend on tour with visitors through the asylum's grounds I also encountered current and former residents: silent and symbolic representations of their historical lack of voice 'to share their insights' or to give 'some idea about what they were thinking' (Reaume 1994:400). Occasionally, the silhouette of a young male patient would appear in the distance, his body language signalling the effects of his medication while at the same time silently evoking a powerful counter-narrative to the tour guide's recollections of the asylum's architectural design features and its environmental history. It was not unusual for a former resident to materialise in the Museum, seemingly out of nowhere. The mute presence of Joe, now living in the community, silenced by his madness or by decades spent living in Kenmore, yet compelled to return, to take up a broom and sweep the familiar spaces of his former home, was a familiar if somewhat unsettling sight.

I increasingly regarded the Kenmore Hospital Museum as a memorial site created by former nursing staff, and my exposure to its nostalgic and celebratory

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[24] Similarly, Coleborne observes that volunteers of the Western Australian Mental Health Museum interpreted museum artefacts through their knowledge and experiences of psychiatric nursing (Coleborne 2003:191).

view of the asylum sensitised me to the politics of representing and interpreting the past (Coleborne 2003; Hodgkin and Radstone 2003:1; Wilson 2005). I also came to appreciate that the kinds of memories available to former staff in group discussions and during one-on-one interviews in private homes were negotiated through what Radstone has described as 'complex psychical and mental processes' (Radstone 2005:135). When collecting information by interview or group discussion, I therefore learned to allow for the effects of memory. Not surprisingly, I encountered a range of memory effects: from nostalgia to negative and traumatic memory (Hirsch and Spitzer 2003:84). The recollections of nursing staff and, subsequently, the psychiatrically dis-ordered and their families and community sector workers fluctuated between nostalgic and traumatic memories, between nostalgia for an idyllic working past and traumatic remembrances such as, for example, suicide, violence, human rights violations and family breakdowns.

I interviewed and/or conducted group discussions with 15 (12F, 3M) nursing staff/family members. For most of the former nurses I interviewed and/or held group discussions with, Kenmore was their main place of employment throughout their working lives. Female research participants tended to arrive at Kenmore in their teens, take time out to have children, and return to Kenmore when family circumstances permitted. A working life at Kenmore spanning three decades was not unusual. Two of the 15 research participants commenced working in the asylum in the 1940s, two in the 1950s and seven in the 1960s. The remainder were either associated through family (2) or commenced work in the 1970s (1) or 1980s (1). During fieldwork, one former nurse passed away.

In the course of research, some inconsistencies and inaccuracies of nurses' recollections became notable. For example, key informants were adamant that the introduction of the pension for asylum residents (described in Chapter12) occurred in the Whitlam era of government (1972-1975), an era noted for its widespread social reform agenda. Yet in Annual Reports of the Director of State Psychiatric Services, Kenmore Hospital has reported on actual numbers of patients eligible for the pension, commencing as early as 1968.[25] Similarly,

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[25] After reading a draft of my thesis, my key informant for and gatekeeper to the Kenmore Hospital Museum and its volunteers referred back to the introduction of pensions as follows: 'I still argue that pensions did not get to KH until late 1972-3. What is "Policy" as dictated by a date of recommended implementation and ACTUAL PRACTICE can vary by months/years. It is possible that NEW admissions had access to pensions, but those who had been patients for many a long time took longer to process' (emphases in original).

nurses' accounts of 'seniority', an ordering system for selecting eligible candidates for promotion described in Chapter 9, was regarded by them as formal policy procedure. The subsequent advice I received from the NSW Nurses' Association, however, was that this 'next in line' process functioned as an informal system only. I thus discovered that the concepts of 'memory' and 'truth' are indeed 'unstable and destabilising terms', and that history is 'constituted in narrative, always representation, always construction' (Hodgkins and Radstone 2003:2). My response was to verify data, where possible, through a process of triangulation.

Despite the limitations of memory, oral history remains a powerful strategy for creating text through the interweaving of voices of those whose stories have traditionally been overlooked or denied. While historical accounts have diversified to include the stories of the defeated and the dispossessed, the writing of history will, however, continue to remain an interpretive process of deliberate and/or unconscious selections and omissions, of privileging some voices and events over others, in accordance with institutional constraints and objectives. Kenmore's medical records are thus more than cultural artefacts of an objective past. To paraphrase Diamond, the records were created by representatives of medical authority who created facts in accordance with the relevant administrative procedures and psychiatric knowledge, who denied voice to inmates, apart from recorded examples of their insanity as justification for their confinement (Diamond 1974). The interpretation of Kenmore's past is thus open to the contested memories of its former staff and residents, to the subjective creation of its medical records, and to the social situatedness of the researcher.

The publication of my research findings in the local media highlighted the contestedness of 'facts' and 'truths,' the subjectivity of interpretation and transcription. I had naively agreed to be interviewed by a journalist on the understanding that her newspaper had authorial control and copyright over my story. The creative license of the journalist resulted in a sensationalised account of Kenmore[26] and its history. The story was run in Canberra and subsequently, Goulburn, the closest town to Kenmore. Mental health consumers interpreted the newspaper article as evidence of my 'pro' asylum stance. In contrast, former

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[26] *Kenmore's dark secrets. New research unearths the shocking truth about the treatment of Canberra patients at Kenmore Mental Hospital from 1925-1951*, Canberra Times 20 March 2004.

nurses interpreted it as an ‘anti’ asylum story that reignited simplistic stereotypes of the asylum as *a mean and nasty institution*.[27]

Methodological reflections from the community

At the same time as I commenced research at Kenmore, I slowly gained access to a range of field sites in Canberra’s mental health community. Fieldwork based on participant observation with live and at times unruly research subjects poses different kinds of methodological challenges than those from working with historical texts. The fields I worked in provided opportunities for dialogue, but at times they were initiated and managed in ways I had no control over. In contrast with my orderly and planned research forays into the asylum’s medical records, my encounters with the community were at times awkward and confronting on a range of levels. In an email to a friend late in 2003, I wrote:

> *Fieldwork is full on (after talking to you yesterday I had a two hour conversation with a consumer who was in a manic state – he called into my office unexpectedly). I am doing a lot of interviewing at the moment, including former inmates of Kenmore. It’s emotionally exhausting and rather disturbing. And frightening as well. After today’s effort, of listening to stories of electric shock therapy, isolation, symptoms of madness, assault, deprivation of freedoms, poverty, loneliness ... the list goes on. It all sounds like one never-ending nightmare for some people. All I feel like doing tonight is crying. This time last year I was feeling traumatised by reading patients’ case notes, medical journal accounts of women being tied to seats for years on end, etc. Right now it’s worse, because these people are alive and sharing their experiences with me, and even worse, nothing has really improved in governments’ treatment (there is no care) of mad people.*

Participant observation does not provide a protective distance and separation of time and space between the researcher and the subject and object of research. Without this protection, the reflexive researcher may become aware of her multiple and inconsistent ‘standpoints’ and subsequently, those of her colleagues. When they were informed that I had invited consumers, carers and workers to a seminar presentation, several staff and students in the academy joked about playing a game they referred to as *spot the nutter*. The idea of family members or community workers attending a seminar evoked little interest, but the prospect of the unpredictable and the irrational entering their intellectual *habitus* provoked a combination of uneasiness and schoolboy humour, romanticised depictions of mad professors and the maddening profession of academia. Researchers, I

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[27] Personal notes and verbatim quotes from research participants are italicised throughout the thesis.

discovered, do not stand outside the practice of *othering* those perceived as different to *us:*

> *I see in myself someone who at times is fearful of mad people's inappropriate, irrational and unreasonable behaviour. And I am also learning that their behaviour is culturally alien to me. In fact, one could even say they live without culture because they do not share our values, aims and goals.* [Journal entry 2003, emphases added]

The social processes of stigmatising difference are not confined to intolerant or ignorant communities of individuals from which *we*, as researchers, distinguish ourselves: in the micro-instances of everyday sociality, we are all implicated in *othering* difference. I recorded this journal entry after a difficult and confronting interview with a consumer who was experiencing delusions and hallucinations:

> *... yesterday turned out to be a pretty intense kind of day. Had the most disturbing and difficult interview to date. The woman* [Nicole] *talked of conspiracy theories, voices on the radio, etc, and was at the same time very suspicious and distrustful of me. And very angry at just about everyone with whom she had come into contact, to the degree of making official complaints. Afterwards, felt that I wouldn't be surprised if she made a complaint about me. Typed out a record of conversation and left it in* [supervisor's] *pigeon hole – felt the need to cover my tracks.*

Nicole described an interview with a psychiatrist during her first week as a patient in the PSU. During her consultation with the clinician, Nicole stated that as far as she was concerned, there could be aliens on the planet – that is not to say she believed there were aliens, but that no-one could say with complete certainty that there weren't any. I responded that perhaps it was unwise, as an involuntary patient of a psychiatric ward, to assert the possible existence of aliens to one's psychiatrist. Nicole's response was that she believed in the freedom of speech and that she was not going to start censoring her words: *I'll say what I think*.

Nicole may not have known that, if there were such an entity as an alien on this planet, at that moment I considered her a likely candidate. I felt uncomfortable in the face of her aggressive assertions about voices emanating from her radio and her bizarre accusations about people she had encountered. I also recollect experiencing a growing understanding and appreciation of governmental powers for the forcible removal from community of those persons we consider to be irrational and strange. I present this unflattering portrait of my response to psychiatric dis-order to illustrate my *othering* of a person apprehended as alien to my cultural standpoint, in other words, the powerful effects of *my(our)* fears of cultural otherness.

In addition to ethical questions about whether I should continue with the interview, Nicole's comments also made me question the quality of my interview data. In a journal entry later that day I wrote:

> *What kinds of truths am I going to get? How do I evaluate what is true or untrue? Why should I assume that a mental health professional's story is going to be in any way a more truthful account than that of a consumer? How do I know who is rational/irrational, mad/sane? Should I privilege one story over that of another?*

I had already experienced the kind of 'truth' that representatives of government were likely to provide me, that is, *policy speak* in a vacuum of unspoken utterances:

> *Talking to mental health government staff is so different than talking to community sector workers. The latter group are not at all defensive, like they've got something to hide, are under siege, etc. Whereas the former do act like they have lots of things to hide. There's a real barrier in getting to talk to the workers. Instead, it gets suggested that I go to the 'community feedback forum' (so, rather than direct communications, it's all about going to structural mechanisms put in place to 'deal' with the public). Lots of barriers. Hmmm. Whereas it was so easy getting access to the community sector. Why? Is it because the government has the power to involuntarily detain and treat people? The right to take away people's freedoms?* [Journal entry 2003]

I decided that ending the interview with Nicole could be interpreted as a patronising gesture and we continued talking for its duration, of about an hour. At the same time, I did not introduce any new themes into the interview, allowing her to direct the conversation.

> *... on my way to* [friend's] *house later that day, I was given these interesting insights of the interview encounter ... I will not be privileging one voice over another, not labelling one kind of person as rational and another delusional. Each will be validated on its own terms. Because after all, how am I to assess what is true, what is not true? ... someone with a position of authority may, I believe, be just as paranoid (or even more) and tell me all kinds of truths etc than the next person. There will be no hierarchy of truths.* [Journal entry 2003]

The transcript of the interview represents a rich account of the experience of involuntary confinement in the public Psychiatric Services Unit (PSU) in The Canberra Hospital, certain details of which were subsequently verified in interviews with other research participants.

Several months after my encounter with Nicole I interviewed 'Jeremy':

> *This afternoon interviewed a consumer – a man who sounded rather strange over the phone. Gave* [supervisor] *his address (in case I didn't return) and he suggested phoning me* [on my mobile] *at a certain time. As it turned out, I was glad to have that insurance because the man locked me in his flat – with a key* [that he kept upon his person for the duration of the interview]. [Journal entry 2004]

It was disconcerting, to say the least, to be locked in an apartment with a man who was a stranger to me and who was also exhibiting *strange* behaviour. Jeremy was not psychotic but his behaviour during our interview deviated from the norms of a social etiquette I was comfortable with.

Subsequent reflections on my response to these examples of irrational, strange and/or difficult behaviour provided me with insights into the pervasiveness of a view of the psychiatrically dis-ordered as somehow culturally distant or defective, bearers of what Barrett describes as a flawed personhood (Barrett 1998[c]:632). It also provided me with insights into the pervasiveness of our fears of the cultural Other.

A final approach for analysing field data was inspired by Rogers *et al:*

> Our approach starts from the premise that the views of users of mental health services are valid in their own right. We do not assume that these views are a definitive version of reality or the 'truth', but they are a legitimate version of reality, or a truth which professionals and policy-makers should no longer evade or dismiss. We assume that people think about and explain the causes and experience of their mental health problems, use of services and treatments in their own way, and that this is worthy of documentation. (Rogers *et al* 1993:13, quoted in Reaume 1994:400).

My approach is broader than the Rogers *et al* study in that it encompasses data from carers and community sector workers and nurses as well as consumers. A culturally relative stance is taken, that considers each perspective as valid, in its own way contributing to the contested stories of care. This stance evolved in response to the markedly different discourses of care I was exposed to while in the field. Wherever possible, 'facts' open to verification have been checked by the method of triangulation. Each research participant was also provided with a transcript of interview or discussion, giving her or him the opportunity to exercise editorial control. A minority of the carers, workers and nurses and 50% of consumers made some editorial changes, mainly by providing further clarification, correcting any inaccuracies or making additional comments. Some informants from the asylum and the community were also provided with selected thesis chapters to ensure as much as possible that the contents were in accordance with their understandings of the issues and events. Other ways of verifying that my thoughts and writings were broadly relevant to stakeholder understandings included presenting my findings at consumer, carer and community sector fora. Presentations were useful in generating discussion and debate, providing a sounding board on the veracity of the data and my thinking at the time on the dynamics of care.

4. Subjects in Need of Care

As my thesis contends that the subject of care is historically, medically and socially constructed, this challenges my efforts in ‘knowing’ the ‘real’ subject of care. Archival records and policy discourses in combination with the voices from the field can provide only partial insights. In addition to this methodological challenge, Condrau articulates ‘a plea’ for historians ‘to define arenas of “patients” and to understand that the sum of these arenas may not reveal the real patient’ (Condrau 2007:536).[28] My response has been to liken the subject of care to an analytical prism[29] with facets that are reflective of multiple and competing perspectives: while each facet may be momentarily ‘real’ it also remains ultimately elusive. At the same time, it is tricky and quite likely a fallacy to maintain that each facet illuminates separate and discrete insights into the subject of care: clinical diagnostic categories and personal identities may seep out and infiltrate one another (Barrett 1998[a]:473). Textual representations may converge with consumers’ narratives of succumbing to psychosis, and carers’ accounts of managing unruly adult children may collide with the policy language of the empowered and autonomous consumer.

I have learned to accept that each section of my thesis can explore only limited facets or ‘arenas’ of subjects of care and that these ‘realities’ will remain partial and constructed, contradictory and contestable. I recognise that the sum of these facets or ‘arenas’ do not reveal the ‘real’ person living with a psychiatric dis-order. Like a prism, the subject is multi-faceted, an amalgam of multiple and contested observations and experiences, interpretations and explanations. However, my epistemological position is not so rigidly allied to the circular logic of postmodernism that I will allow it to limit me from exploring discursive themes arising from the field that imbue the facets of this analytical prism with meaning.

At the risk of conflating historically specific psychiatric knowledge claims, this chapter describes the premises of psychiatric primitivism which are,

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[28] Condrau’s plea is in acknowledgement of Porter’s influential article ‘The Patient’s View: Doing Medical History from Below’ (*Theory and Society* 14, 1985). According to Condrau, Porter’s ‘strategies and broad interpretive guidelines for future investigations’ (Porter 1985[b]193) remain ‘uncharted territory for historians of medicine’, and this he attributes to a tension between empiricism and a Foucaultian approach (Condrau 2007:526,535-536).

[29] The prism is not a novel analytical concept. For example, Donzelot described vagrancy as ‘the prism through which all the categories of madness and abnormality could be distributed’ (Donzelot 1979:130, cited in Hacking 1998:69).

according to Barrett and Lucas, ‘one of the principal means of understanding madness in western psychiatry’ (Lucas and Barrett 1995:313-314). Further to Barrett and Lucas, I propose that psychiatric primitivism is not contained by the boundaries of a scientific discipline of theory and practice but has infiltrated a wider discursive domain. In the course of my fieldwork in the asylum and the community, psychiatric primitivism emerged as a cultural narrative that was used to understand and explain psychiatric subjectivities. I recognise that the sum of its premises does not represent the ‘real’ subject of care. Ultimately, psychiatric primitivism reveals more about normative culture than it does about the subject. Secondly, it is not my intention to ‘know’ the ‘real’ subject of care but rather to better understand the rationales for care. Fitting in with my project of articulating a history of the arts of care, the language of psychiatric primitivism thus provides a cultural narrative for apprehending how the psychiatrically dis-ordered were recognised as being in need of care, which thereby justified their subsequent segregation, detention, rehabilitation and resocialisation.[30]

Psychiatric primitivism

How do *we* recognise a person as in need of care? And in this cognitive process of recognition, how do *we* make decisions on the appropriate treatment? The consequence of this recognition – diagnosis of a phenomenon *we* describe as madness, mental illness or psychiatric dis-order - means different things to different people. For the consumer it may mean ‘suffering, loss of liberty, discrimination’, for families ‘the burden of care, shame’, for nursing staff ‘managing doctors and patients’, and for doctors it may invite consideration of a ‘medical and scientific “problem”’ (Engstrom 2003:10). Based on the data arising out of my field research, one of the more persistent narratives for recognising a person is in need of care draws its logic from the thinking underpinning what Barrett and Lucas refer to as psychiatric primitivism.

In the course of researching the arts of care I became aware of the different ways in which the language of degeneration and deterioration permeated each care regime and how the subjects of care were alternately infantilised, demonised and/or romanticised in texts and in utterances emanating from the field. In addition to being portrayed as irrational and sad, subjects of care were at times

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[30] The scope of this chapter therefore does not extend to an interrogation of the ‘science’ or ‘truth’ of psychiatric primitivism or psychiatric knowledge.

also described as violent and unpredictable; animalistic; as child-like and in need of paternalistic care; and as creative or plain *weird.* These descriptions were differentially articulated in the texts of psychiatry, bureaucracy and the law; and voiced by nurses and family members *as well as* by the subjects of care.

Psychiatric primitivism is a way of thinking that makes obvious some of the moral, political and evaluative dimensions of psychiatric dis-order:

> Madness and reason exist in an oppositional relationship. What is considered normal defines what is considered insane in society and vice versa, and these constructions can change over time. Some common dualisms associated with the reason versus madness paradigm include: rationality versus irrationality, thinking versus feeling, maturity versus childishness, humanity versus animality, virtue versus perversity, civilisation versus savagery, and so on. (Lucas and Barrett 1995:313)

Forms of sociality and its membership tend to be imagined in opposition to what they are not, and the signs of mental distress are therefore relational to the norms of the culture in which they emerge. In western states, psychiatric dis-order is positioned in opposition to the values and beliefs of the ‘Age of Reason’ and aligned with notions of irrationality, degeneration, deterioration and/or disintegration (Hacking 1998:27). Understandings of psychopathology thus overlap with boundaries of badness, immorality, and potential criminality as well as cultural difference. Within this explanatory frame, the arts of care prescribed or offered by asylum and community are not only to provide ease, comfort, and support for the mentally afflicted. The arts of care also offer the promise of civilisation: the ideal care-provider is a role model of civility, the act of care a performance in sanity - a ritual for guiding the psychiatrically dis-ordered to return to culture.

Psychiatric primitivism does not represent an homogeneous discourse: it draws upon two understandings of the primitive. The Barbarian primitive tends to be described as ‘animalistic and inferior’ and ‘violent’ while the Arcadian primitive is typecast in terms reminiscent of the *noble savage*, as creative and living a harmonious ‘life of innocence and simplicity’ (Lucas and Barrett 1995:289-290). These categories give rise to different understandings of primitivism. The Arcadian perspective implies that the primitive has a culture, albeit a simple one that has been formed in intimate response to the cyclic rhythms of nature and against a Western, scientist rationality, whilst the Barbarian emerges as a figure too brutish and primitive for any kind of culture. These binary understandings of the Arcadian and the Barbarian are useful in apprehending firstly, some of the complex and contradictory underpinnings of psychiatric primitivism and secondly, the coercive and rehabilitative arts of care that have been devised to manage and/or restore them to sanity and civility.

Lucas and Barrett argue that it is the Barbarian primitive, an ‘unpredictable’ subject existing without culture and ‘associated with degeneration, disruption and pathogenesis’, that dominates psychiatric theory as the archetypal *madman* (Lucas and Barrett 1995:289,315). The Barbarian informs our understandings of psychopathology and the lifestyle of the Arcadian, as ‘pristine, harmonious and therapeutic’, tends to be equated with pathways to recovery reminiscent of Tuke’s vision of moral treatment, of the calmative properties of nature, of art and music as creative forms of therapy (Lucas and Barrett 1995:289,315). In the chapters that follow, I use the Barbarian to inform understandings of psychiatric subjectivity while Arcadia represents not a figure but rather, an idealised setting for restoration of sanity and civility.

Lucas and Barrett may have been influenced by a reading of Foucault’s *Madness and Civilisation* in which primitive states of being resembling the Barbarian and the Arcadian are proposed. Foucault describes the ‘Savage’ and the ‘Laborer’ in ways reminiscent of the typology constructed by Lucas and Barrett: the Savage is a being of ‘immediate desire, without discipline, without constraint, without real morality’, while the Laborer’s ordered routine ‘cures’ madness: ‘the rhythm of the days and the seasons, the calm necessity to feed and shelter oneself, constrain the disorder of madmen to a regular observance’ (Foucault 1964:184-5). The return to sanity by adherence to the mundane routines of the Laborer is effective because it ‘dismisses from man’s life and pleasures everything that is artificial, unreal, imaginary’ (Foucault 1964:183). A return, perhaps, to the simplicity and harmony of an Arcadian setting.

To some degree, the categories of primitivism developed by Foucault and Lucas and Barrett are paralleled by Porter in his discussion of mood disorders. Mania and melancholy, paired yet always contrasted, he writes, ‘dominate our conceptualisations of madness’ (Porter 1995[c]:411). He describes the stereotypical maniac in terms reminiscent of the Barbarian primitive, as ‘brutal’ and ‘behaving like [an] animal’ (Porter 1995[c]:412). In contrast, melancholy, or the current diagnostic term of depression, is attributed to the understandable response of a creative, artistic and sensitive mind to the pressures of living in a modern, Western society. A link between the melancholic and neurotic and the inhabitants of Arcadia is implied through their creative sensibility: '(t)he Arcadian Primitive is not likened to the mad person, except in so far as both may be regarded as sources of creativity' (Lucas and Barrett 1995:297). Any further resemblance between these types in the writings of Lucas, Barrett and Porter is not discernable for while the Arcadian lives in a pristine, bucolic existence, the melancholic and neurotic are suffering a disease brought on by societal stressors.

Distinctions between the melancholic and neurotic and the archetypal *madman* become more obvious when one contrasts them with the norms and the problem of western civilisation. According to Campbell, we have sympathy for the melancholic and neurotic because they are suffering from the 'disease of modern civilisation' and, most important, they have the sensibility and intelligence to suffer a complex neurosis (Campbell 2007:162, 175). Porter adds that we understand the melancholic 'because he is our self' or perhaps our idealised self, whereas the manic remains 'alien' and potentially dangerous (Porter 1995[c]:419). Pilgrim similarly notes that:

> Lay people typically connect depression with everyday life and its vicissitudes rather than the alien world of madness, a distinct category of experience that happens to the 'other'. (Pilgrim 2007:542)

Representations of Barbarian and Arcadian primitivism may also reveal different ways of perceiving modern western society, for example, in terms of progress or societal disintegration (Lucas and Barrett 1995). Table 4.1 below outlines how, in the former version, a progressive West is more likely to be contrasted with a Barbarian or Savage, while a socially disintegrated West is situated opposite to the harmonious community embodied in the lifestyle of the Arcadian or Laborer:

Table 4.1. Barrett's Typology of Primitivism[31]

	Barbarian Primitivism	**Arcadian Primitivism**
Modern Society	**Positively valued:** • Progress • Science • Rationality • Control	**Negatively valued**: • Individualism • Disintegration • Alienation • Division and conflict
Primitive Society	**Negatively valued**: • Backwardness • Magic and witchcraft • Irrationality, superstition • Impulsivity	**Positively valued:** • Community • Integration • Involvement • Harmony

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[31] Barrett 1998[a]:487.

In the case where modern society was positively valued and primitive society associated with negative values, this form of thinking was also in alignment with governmental concerns of rule over internal and external subjects. From the mid-nineteenth century onwards, a dominant discourse that combined the premises of psychiatric primitivism with the problems of government was degeneracy theory. As civilisation contrasts with madness; similarly, degeneracy is the opposite of progress for 'the idea of progress by means of a logic of growth' includes 'a pathology of decay' (Chamberlin 1985:263). While 'madness proper' represented a threat to civilisation by its diametrical location opposite reason and rationality, degeneration challenged the Enlightenment norm of the 'growth ethic' (Habibi, quoted in Arneil 2004:9). Degeneration was thus the antithesis of 'development, cultivation, improvement, refinement, progress, and the elevation of character' (Arneil 2004:10). Degeneracy could account for the disruption to Arcadia, the repercussions of the shift from *Gemeinschaft* to *Gesellschaft*. Degeneracy also provided a scientific language for describing and explaining the signs of primitivism.

The Threat of Degeneration

By the mid-nineteenth century, degeneracy became the dominant term for voicing concerns regarding the moral, mental and physical health and well-being of populations.[32] It was not only a scientific discourse for dividing the competencies of citizenship and sanity from defective otherness, it also provided another way to understand madness and to articulate cultural otherness:

> (i)n the classical period, indigence, laziness, vice, and madness mingled in an equal guilt within unreason .... Now madness belonged to social failure ... Half a century later, mental disease would become degeneracy. Henceforth, the essential madness, and the really dangerous one, was that which rose from the lower depths of society. (Foucault 1964:247)

Degeneracy theory was popularised within clinical medicine by Bénédict-Augustin Morel, a French psychiatrist and former asylum director. Morel's 'Treatise on Physical and Moral Degeneration' published in 1857 was his most influential contribution. Barrett describes Morel's thinking as a combination of biology and Roman Catholic theology, especially the notion of Sin (Barrett 1996:191). Morel posited two main laws of degeneracy: heredity and progressivity, that is, accumulative defects over generations (Carlson 1985:122).

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[32] In nineteenth century German psychiatry, for example, madness was attributed to 'moral *decline* and national *degeneration*' (Engstrom 2003:31, emphases added).

Encompassing the intertwining of theological, racial, criminological, political, and Lamarckian evolutionary ideas, degeneracy theorists gave dire warnings of physiological and moral regression to an earlier, primitive state of being. Some of Morel's most influential contributions to psychiatry include his writings on the course of dementia praecox (schizophrenia), a phenomenon whereby seemingly healthy adolescents deteriorate in young adulthood; the mental and physical decline associated with neurasthenia; the link between defective ancestry and retardation; and the degenerative processes of alcoholism (Carlson 1985).

Degeneracy was used to explain psychiatric theories of nosology and aetiology. Providing a commentary on Morel's laws, Porter notes that '(a) typical generational family history might pass from neurasthenia or nervous hysteria, through alcoholism and narcotics addiction, prostitution and criminality, to insanity proper – and finally utter idiocy' (Porter 1997:510). In his historical investigation of the ecological niches 'within which mental illnesses thrive', Hacking observes nineteenth-century French knowledge-claims that alcoholism and dipsomania 'could be inherited, and both could lead to the family line becoming degenerate, so that drunkards would breed hysterics who would breed epileptics. Hysterics and epileptics were degenerates' (Hacking 1998:1, 65).

The adherents of a neo-Lamarckian worldview believed that 'dissolute and depraved conduct exacted a heavy biological price' on subsequent generations (Scull 2006:119) whereby,

> constitutional defect, in its turn, was transmitted without fail to succeeding generations, remorselessly bringing in its train alcoholism, criminality, madness, idiocy, sterility, and death. (Scull 2006:119)

Degenerates were more likely to be found among the over-breeding, illiterate populations of the working-class poor (Nye 1985). Indeed, earlier that century, campaigners for the asylum solution had contrasted its therapeutic capabilities with the inadequacy of working-class families to provide appropriate care for the insane, such as the case of Mary Jones in Wales who was discovered living:

> On a foul pallet of chaff or straw … in a dark and offensive room over a blacksmith's forge … here she had been confined for a period of fifteen years and upward. She was seated in a bent and crouching posture on her bed of nauseous and disgusting filth.[33]

It was not surprising, then, that half a century later such defective families were implicated in the rise in the number of degenerates.

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[33] Hansard 81, 3rd series, 1845 cols. 185-186, cited in Scull 1983:331.

Classificatory schemes were devised whereby physiological signs of degeneration were used as evidence of a decline in morality, the hallmark of civilisation and progress (Rimke and Hunt 2002:75). Degenerates - ‘evolutionary throwbacks’ – were physically identifiable by ‘physical stigmata: low brows, jutting jaws and so forth’ (Porter 1997:511). Comparisons were made between the physical attributes of degenerates living in Western societies with non-European races and apes (Porter 1997:511). Degeneracy was used as an explanatory device for articulating differences in race, sex and class; its explanatory power at the same time also legitimising prejudice and discrimination, whereby the working-class poor, the Negro, the homosexual, the criminal and the insane were situated on the lowest rungs of a quasi-scientific, moral hierarchy (Stuart Gilman 1985:172-3; Barrett 1996:192).

One of the consequences of the rise of degeneracy theory within clinical medicine was the increased incarceration behind asylum walls of a wide range of defective or backward Others, degenerates who, alongside the insane, were deemed to be in need of institutional care. The role of asylums was to care, treat and detain not only the insane but also a broad and diverse ‘polity of individuals lacking inner autonomy’, including persons exhibiting the signs of natural degeneration associated with old age and infirmity, defective ancestry and immoral behaviour, for example, of idiocy and drunkenness as well as the symptoms of psychopathology (Engstrom 2003:23; Finanne 1981:143,145). Thus, asylum care was directed towards motley groups ‘which concerned madness proper’ and in addition, it also addressed ‘those called, without exact semantic distinction, insane, alienated, deranged, demented, extravagant’ (Foucault 1964:62).

The proliferation of asylums had a calmative effect on the bearers of bourgeois morality, assuring them that they could contain the supposedly rampant spread of social, mental and physical degeneration amongst certain population groups. Ideally, moral treatment would restore transgressors to culture by taming the primitive within (Scull 2006:113). In the meantime, the community would be protected from chronic degenerates through their segregation and containment. After the rituals for removal from the community and asylum committal had been performed, inmates were physically divided up and segregated according to sex, not only to enforce the norms of moral conduct but also to limit the reproductive capacities of degenerates (Gittins 1998:19).

In addition to their role in controlling the spread of degeneracy, asylums alleviated the family burden of caring for unproductive relatives. They were increasingly regarded as a solution for managing troublesome and troubled individuals who had exhausted the limits of community tolerance and/or capacity for care. Under this governmental regime, asylums proliferated and became increasingly overcrowded. The outcome of this policy was the accumulation of chronic cases in North American and European asylums.[34] While the accumulation of chronic cases may have been interpreted as a sign of the limitations of psychiatric treatments, degeneracy theory and the notion of heredity provided an explanation for the profession's failure to effect reasonable rates of cure. Degeneracy theory absolved psychiatry of its failure to cure by locating the continued unresponsiveness of certain inmates 'within the patient and his or her genetic endowment' (Barrett 1996:188). Indeed, Barrett notes, 'incurability was an organising principle of nineteenth century psychiatry' (Barrett 1996:209).

While the nineteenth-century language of degeneracy no longer forms part of public health discourse, the moral meanings associated with this term have not been abandoned. The ideas underpinning degeneracy are malleable and open to mutation across space and time and, borrowing from Rimke and Hunt's writings on the 'never-ending project of the improvement of morals', continued to 'reappear in different guises' and in 'various combinations' in the twentieth-century (Rimke and Hunt 2002:60-61).[35] Tactics for the government of the irrational, the irresponsible and the unproductive are driven by the cultural norm of the 'growth ethic': they have mutated but they have not lost their moral saliency. Scientific narratives for expressing anxieties with reference to the moral, mental and physical health and well-being of populations continue unabated, dividing the competencies of citizenship and sanity from defective otherness. At the same time as their explanatory powers articulate governmental

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[34] In contrast, the York Retreat was selective about the kinds of persons it admitted, and turned away 'even potentially lucrative cases of "incurables".' Stewart attributes this selectiveness to the growing popularity of the Retreat and the competitiveness of its admission process (Stewart 1992:33). One could also suggest that the Retreat's selectiveness may have contributed to its success rates.

[35] A lineage of nineteenth-century concerns of moral, physiological and psychological regression of certain population groups may be traced in eugenicist theories, the mental hygiene movement and early intervention programs (Barrett 1996; Coleborne and Mackinnon 2006; Dikötter 1998; Finnane 2003; Garton 1994, 2000; Hacking 1998).

concerns regarding the lifestyle and habits of different groups in the population they may also legitimise prejudice and discrimination.[36]

Early intervention, as the term suggests, is about taking remedial action at a stage of the individual's mental or physical deterioriation that is prior to the point where recovery and cure become near impossible. In twentieth-century NSW asylums, early intervention was regarded as an important factor in the prognosis for recovery and cure. In his 1929/30 annual report, the NSW Inspector-General of Mental Hospitals writes that:

> The suggested new provisions of the Lunacy Bill would … render easier the admission to hospitals of patients suffering from mental diseases in the early stages, and the fact of their being treated as ordinary sick persons in ordinary public hospitals would, no doubt, be the means of many seeking treatment at a time when their disease was more amenable to treatment. At the present time, treatment not being afforded until the patient is certifiable, many forms of mental disease which may otherwise have been cured have reached the unrecoverable stage.[37]

Early intervention became, and remains, a national priority area of late twentieth-century Australian mental health service provision (see, for example, the *National Standards for Mental Health Services 1996*, the *National Mental Health Strategy 1993-2003*, and the *Second National Mental Health Plan 1998-2003*). It is believed that mental health promotion and prevention and early intervention in childhood or early teenage years will yield greater success in the treatment or prevention of psychiatric dis-orders. It implies the importance of early treatment to halt the process of degeneration. It also legitimises the widening of the psychiatric net as our behaviour comes under greater scrutiny for signs of psychopathology (Scull 1979:266). Early intervention programs in childhood or teenage years may target schools or be specifically devised for the progeny of problem populations, those children viewed to be at high risk of developing a psychiatric dis-order. In a national review of mental health stakeholders, including consumers, carers, and providers, participants recommended targetting:

> (c)hildren experiencing trauma and maltreatment; children in alternate care; Indigenous populations; young offenders; children of parents with a mental illness;

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[36] For example, in response to a report setting out claims of widespread sexual abuse in Aboriginal communities in the Northern Territory, the Australian Government suspended the Racial Discrimination Act in 2007 in order to mobilise an Intervention into Aboriginal communities. Not to deny the reality of complex social, health and economic 'problems' faced by Aboriginal and Torres Strait Islander peoples, the powers vested in the implementation programs of the Intervention symbolise a paternalistic and racist response by Government to 'Aboriginal deficit'.

[37] As stated elsewhere in the thesis, voluntary admissions became formally available after an amendment to the NSW *Lunacy Act* 1898 was passed in 1934.

> children with chronic illness; and, young people with substance abuse problems. (Mental Health Council of Australia 2003:30)

Alison and Linda regarded early intervention as a crucial component in the effective management of psychosis. They described the impact of early intervention policies over time on the kinds of patients that were brought into the asylum:

> *Alison: You'd always have that group that was treatment resistive. ... Really disturbed.*
> *Linda: And they were truly disturbed, not like the kind of drug-induced kids you get in these days.*
> *Alison: They were real classic textbook examples of psychosis and you don't see them anymore.*
> *Doris: It's interesting that you say that because that's what Brenda was saying too, that you had different, that the type of people that were coming in were different than the type of people that are around today.*
> *Alison: Well you don't see any more, well I haven't seen any, things like ah catatonic schizophrenics. And they were either in the process of catatonic excitement where you could hardly keep up with them during the day, or catatonic stupor. And sometimes that one person fluctuated from one extreme to the other ...* [discussion of a previous patient] *she was one that was schizophrenic and had catatonia. She was either roaring around the – you really had to run with her just to give her a sandwich in the hope that she'd eat something. .... but when she was in catatonic stupor she'd just stand there in a corner of the ward all day and, you knew she was taking everything in, but she was mostly mute. ...*
> *Doris: So why aren't we seeing these types of people these days?*
> *Alison: I think, is it because we get to people earlier in their breakdown? Um, to intervene with medication. We've got better medication.*
> *Doris: So this woman you were referring to would have become ill at a time where psychotropic medications hadn't been that available.*
> *Alison: And she probably would have had too many psychotic breakdowns or relapses.*
> *Linda: Now I haven't worked for what how many years now, eight years or something, but it was years since I'd seen anybody, you know a true genuine psychotic, other than drug-induced and everything ...*

Their comments suggest that without early treatment, a degenerative and deteriorative process may take effect, causing irreparable damage. Their observations of the 'catatonic schizophrenic' are interesting as they illustrate Barrett's reflection that 'disintegration and degeneration constitute a pair of metaphors that, among other cultural influences, have shaped the development of the schizophrenia concept, and *continue to affect* the way we think about this illness' (Barrett 1998[c]:627, emphasis added).

Twentieth-century psychiatric Barbarianism

In contrast the psychological ideal of personhood as 'a unified, coherent, bounded whole' (Barrett 1998:632) or the liberal political view of the Western Self as industrious, rational and autonomous (Arneil 2004), ‘schizophrenia still implies an incurable disintegration of the person’ (Barrett 1998[c]:632).[38] Drawing on anthropological fieldwork conducted in an Australian psychiatric hospital, Barrett describes language used by staff that evokes a process of disintegration and division: ‘“cracking up”, “going to pieces”, “falling apart” or undergoing “psychotic disintegration”. ... “beginning to fragment”’ (Barrett 1998[c]:631). The language used by staff is interesting, not for reasons relating to the real or constructed ‘nature’ of schizophrenia but because of the moral authority it gives to care providers and the institutions of care, while at the same time stigmatising the ‘schizophrenics’ as transgressors of culture.

The equation of schizophrenia with primitivism and regression to child-like cognitive capacities implies that a degenerative process has occurred, with a poor prognosis for recovery and/or cure. Writing on her research with families’ experiences in caring for their adult children diagnosed with schizophrenia, Milliken notes:

> Their adult child exists, but with a lack of social skills, education, personality, emotions, abilities, talents, and future prospects. (Milliken 2001:152-3)

Schizophrenia is psychiatry’s ‘hopeless’ case, and this distinction is reflected in the psychiatric profession’s profoundly low rate of treatment success.[39] Furthermore one may argue that the ‘schizophrenic’ evokes fears reminiscent of those induced by the nineteenth-century figure of the homicidal maniac for *he* has been stereotyped by psychiatry and public media as unpredictable and violent and ‘culturally constituted … at the outer edge of personhood’ (Barrett 1998[a]:478). The ‘schizophrenic’ *is* the Barbarian, and images of Barbarianism persist in the literature on schizophrenia:

> (p)eople with mental illness, particularly patients with schizophrenia, are perceived as unpredictable, aggressive and dangerous, less intelligent, and unreasonable. (Stengler-Wenzke *et al* 2004: 88-89)

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[38] I acknowledge the limitations of psychiatric primitivism, which cannot account for divergent ideas within an evolving discipline, for example, the differing understandings developed by Kraepelin and Bleuler on the aetiology, diagnosis and prognosis of schizophrenia. However, I maintain my interest in a ‘broad brush’ historical sociology that questions the persistency of certain beliefs about and descriptions of psychiatric dis-order within social institutions and their implications for relations of care across spatial and temporal borders.

[39] Approximately ‘30 percent of people diagnosed with schizophrenia will attempt suicide, 5 percent will succeed. People with schizophrenia have 2.5 times the death rate of the general population, and their life expectancy is reduced by an average of 10 years’ (Schizophrenia Research Institute, http://www.schizophreniaresearch.org.au/home.asp, accessed May 2008).

The nineteenth-century spectre of the dangerous individual continues to haunt the contemporary fears of the public. In the neoliberal freedoms of late twentieth-century mental health government, this danger is managed through the actuarial measures of risk. Risk has become another way in which to refer to dangerousness and Risk Assessment has become the dominant technique used not only by psychiatrists but by all psy-professionals. Not surprisingly, the diagnosis of schizophrenia is one of the criteria of actuarial risk assessment predictors of dangerousness. Other predictors represent a blend of hereditary and environmental factors, some of which are reminiscent of nineteenth-century conceptualisations of the breeding grounds for degeneracy:

> (b)eing male, ... anti-social traits; suspiciousness, childhood marred by disorganisation and/or abuse, youth, impulsivity and irritability .... lack of education and work skills, itinerant lifestyle, poverty and homelessness; ... low socio-economic groups ... [mental illness] poor compliance with medication and treatment, poor engagement with treatment services, treatment resistance and lack of insight into the illness .... substance abuse .... personality constructs. (McSherry 2004:2)

Furthermore, in his review of the correlation between psychiatric dis-order and dangerousness, Mullen writes that there is an 'increased risk of assaultive behaviour amongst acutely disturbed and deluded schizophrenics' (Mullen 1984:13). He concludes that 'age, the sex, the social class and work skills, the race and the history of substance abuse, all provide indicators to the probability of future offending' (Mullen 1984:14).

In addition to the 'schizophrenic', the personality dis-ordered also fit within the category of person described above. The diagnosis of personality dis-order is commonly associated with young men with substance use issues, a predilection for violence, and a low socio-economic background (Pilgrim 2001:263). Listed in psychiatric diagnostic classification schemes but distinguished from mental illness since World War II, the lineage of personality dis-orders includes the historical categories of psychopathy, sociopathy, moral imbecility, and moral defectiveness (Ernst 1995:650; Pilgrim 2001:254). Personality dis-order may also be traced to the nineteenth-century theory of degeneracy. For example, Berrios notes that 'without the framework of degeneration theory, the concept of psychopathic inferiority would have made little sense' for it was then believed that 'psychopathic manifestations were a manifestation of degeneration' (Berrios 1996:429). In the more recent North American and British psychiatric diagnostic classification schemes, psychopathic personality/dis-order is referred to as ‘dissocial personality disorder’ or ‘antisocial personality disorder’ (Berrios 1996:429).

Pilgrim describes personality dis-orders as ‘a dustbin category of problematic “behaviour” as judged by significant others or staff’ that is based on a circular logic (Pilgrim 2001:255). Kiseley defines personality disorders rather broadly as ‘behaviour which deviates markedly from cultural expectations’ (Kiseley 1999:1410). Thus, the borderline, the anti-social, the histrionic and the narcissistic may be viewed as configurations of cultural otherness. According to Ernst, personality dis-order represents the ‘outsider’ of the moral and medical order, a form of degeneracy intricately associated with ‘sin, vice, and crime’ and, therefore, a ‘close ... bedfellow of mayhem and murder’ (Ernst 1995:645,648,649). Pilgrim (2001) and Ernst (1995:648) suggest that signs of personality dis-order reveal more about the prevailing moral order than they do about the individual: ‘these are moral attributions, not value-free scientific descriptions .... the medical codification of ordinary moral judgements’ (Pilgrim 2001:256).

People diagnosed with personality dis-orders are problematic clients of the mental health system because they tend not to respond favourably to pharmaceutical treatment. Secondly, because aetiology is more likely to be attributed to culture rather than biology (notwithstanding the limitations of these distinctions), a diagnosis of personality dis-order suggests that the person has an element of choice and responsibility for their actions. The personality dis-ordered are therefore more likely to be viewed by governmental authorities and by communities as bad rather than mad, invoking a correctional services response. In the absence of ‘indefinite stay places’ such as the asylum, certain ‘personality constructs’, in particular those persons diagnosed with antisocial personality dis-order, are more likely to be processed through the corrective services system (Lamb and Weinberger 1998; Coleborne and Mackinnon 2006).[40]

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In this chapter I presented psychiatric primitivism – in particular, its Barbarian variant – as a persistent theme for recognising a person is in need of care. The

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[40] Related to this point, in all Australian states and territories apart from ACT and NSW there exists the legislated possibility of ‘indefinite detention’ of categories of persons assessed as being at high risk of offending (McSherry 2004:3).

persistence of this idea is confirmed by my fieldwork. The psychiatrically disordered have emerged as categories of persons whose behaviour deviates from dominant cultural norms and expectations. Not surprisingly, cultural transgressors may at times induce fears and anxieties in *us* and provide justification for segregating and detaining those who are deemed to be irrational, immoral, unpredictable, and/or potentially violent to themselves or to others.

The chapters that follow set out, in an uneven and incomplete trajectory, how environmental settings and relations of care reinforce the premises of psychiatric primitivism through three regimes of care. Families describe their unwell relatives as weird, irresponsible, uncooperative, recalcitrant, vulnerable and dependent; nurses describe their experiences of caring for the most degenerate and deteriorated - *A dog would be better than what you could train her. She just had nothing. It was like a blank* – and relate how they confronted their fears of the unpredictable and irrational:

> *They don't know what mad is until they, until they came out here and, well it took some getting used to, you know, a bloke would be with his face in the wall, laughing his flaming head off, you know, and* [you'd think] *"what's going on there?", you know, yakking away to himself. You didn't know what was, what mad was until you, it took a while until you'd get used to it.*

The threat of violence to self or others imbued the asylum with an air of unpredictability and potential dangerousness. Mechanisms of restraint over unruly residents were built into its moral architecture. Nurses recount how at times the asylum structure was symbolic of a dysfunctional family of violent acts and punitive responses. Carers describe their adult care recipients as irresponsible children in need of repressive care and *tough love* solutions. In the community, research participants describe how middle-class *depressives* are catered for in an *open door*, inpatient ward while *schizophrenics* are more likely to be sent to the *locked door*, disciplinary care facility. Each of their claims symbolise facets of psychiatric subjectivity that are not only diverse but may also be contested.

SECTION II

ENVIRONMENTAL SETTINGS OF CARE

In the previous Section, I outlined a history of the arts of care and considered some of its dynamics, continuities and ruptures. I reflected on methodological issues that arose in the course of fieldwork and discussed how they informed my epistemological position. In the final chapter of Section I, I drew on a cultural narrative of psychiatric primitivism to synthesise findings from the field and to consider the question: How do *we* recognise a person is in need of care?

Section II will focus on the landscapes of care, and explore how they have been designed to seek to return the psychiatrically dis-ordered to civility and sanity. In the asylum, the relationship between psychiatry and architecture, including the uneasy spaces of the asylum between a prison and a hospital, is examined, as are some of the historical events that affected the provision of care in NSW asylums during the twentieth-century. In the community, the emerging vision of psychiatric services for Canberra is discussed, as are the limits of care in the community. A divided community is mapped, based on a typology of community as enabling and facilitative and as a space of surveillance and enforcement.

5. Managing care: the ties between an asylum and a community

This chapter provides an overview of the rationales for the construction of Kenmore and Canberra; the legal instruments in use during the period of my research; and the social conditions in Canberra that precipitated the need for a legal agreement between the asylum and the community.

> During the year an agreement has been concluded between the Commonwealth and State Governments for the reception, detention and maintenance in Mental Hospitals in this State of insane persons and inebriates committed to those institutions from the Territory of the Seat of Government. The agreement has been ratified by the necessary Commonwealth Ordinances and a State Act of Parliament, and is now in operation. (Inspector-General of Mental Hospitals, 1938 Annual Report)

As is not uncommon practice, ratification of this legal arrangement was retrospective: the first Canberra patient arrived in Kenmore Mental Hospital, Goulburn, during the 1925/26 administrative year. Most Canberra patients were sent to Kenmore because it was in closest proximity to ACT, approximately 100 kilometres north of Canberra (Lewis 1988:197). This formal governmental arrangement between Kenmore and Canberra lasted over 60 years until the advent of self-government for the Nation's Capital on 11 May 1989, when it became possible to enact legislation and establish provisions for the involuntary confinement of patients within the Territory's borders. This formally occurred six years after self-government, in February 1995.

Until then, in-patient care available in Canberra was reserved for those who offered themselves voluntarily for treatment, and Kenmore received approximately 100-150 persons – or roughly 3% of Canberra's psychiatric clients - each year. The ties between the asylum and the community, however, were not completely ruptured after Canberra developed its own lock-up facilities. Patients who did not respond in a timely manner to the care and treatment available in Canberra's psychiatric wards were transported to Kenmore.

Lewis describes the following pieces of legislation affecting ACT residents up until self-government as a:

> patchwork of New South Wales law and Territory ordinances: the New South Wales Lunacy Act, 1898; the New South Wales Inebriates Act, 1900-1909; the New South Wales Mental Health Act, 1958; the Seat of Government Acceptance Act, 1909-1973; the Seat of Government (Administration) Act 1910-1973; the Insane Persons and Inebriates (Committal and Detention) Ordinance, 1936-1937; the Lunacy Ordinance, 1938; and the Mental Health Ordinance, 1962. (Lewis 1988:199)

Once admitted to a NSW institution though the provisions available under *Mental Health Ordinance 5 1962 (Australian Capital Territory*), the patient became 'subject to NSW law' (Potas 1982:78). After self-government, the *Mental Health Ordinance* was converted into an Act, and in February 1995, the *Mental Health Act 1983* and parts of the *Lunacy Act 1898* were repealed, and the *Mental Health (Treatment and Care) Act 1994* was implemented at the same time as the Mental Health Tribunal was established in 1995 (*Mental Health [Consequential Provisions] Bill 1994*).

The *Inebriates Act* 1912 was passed in order to provide 'care, control and treatment' of 'a person who habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess' (*Inebriates Act* 1912, cited in Standing Committee on Social Issues Report 2004:15). The powers vested in the *Act* enable a judge or a magistrate to order the detention of inebriates in licensed institutions for up to one year. In the bill proposed before the NSW Parliament, inebriety was associated with the social problem of degeneracy:

> It has been remarked that a vast amount of poverty is due to drink; and that the largest proportion of crime is committed under its influence. We believe that much of the evil so arising would be preventable if proper means were taken to enable … habitual drinkards … to submit to … proper restraint.
>
> … the children of habitual inebriates on either side are less able to fight the world than others, are more likely to be lunatics, and are very likely to become criminals. The passing of legislation such as this, therefore, would add to the well-being of our future population. (Hon JM Creed MLC 1898, cited in Standing Committee on Social Issues Report 2004:17)

Historically, the *Act* has mainly been used to control for and to treat 'difficult' behaviour associated with alcoholics and alcoholism (Standing Committee on Social Issues Report 2004:24,47). Until the closure of the Shaftesbury Institute in 1929, the administration of inebriates was the responsibility of the Prisons Department.[41] Rather than face the financial burden of building a new institution, the government proclaimed a number of mental hospitals, including Kenmore, as 'institutions for inebriates' (Shea 2005:196).[42]

In the lead up to the construction of Kenmore and Canberra, the NSW Legislative Assembly was subjected to a campaign for establishing a new mental

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[41] Shea cites a number of reasons for the closure of the Shaftesbury Institute in 1929, including inadequate staffing, recidivism, and costs associated with running the institution (Shea 2005:196).

[42] While ACT residents are, since self-government, no longer subject to the *Inebriates Act 1912*, residents of NSW continue to be subject to its powers. For example, during the period 2002-04, four NSW psychiatric facilities admitted a total of 45 inebriates for treatment and care (Standing Committee on Social Issues Report 2004:22).

hospital in rural NSW. From the 1860s onwards, the state government was regularly reminded of the problem of Sydney's overcrowded asylums. New solutions were proposed in the 1863 *Report of the Legislative Council Select Committee of Enquiry into the Present State and Management of Lunatic Asylums*, including the establishment of several rural asylums.[43] In 1876, the first NSW Inspector-General of the Insane,[44] Frederick Norton Manning, sought and was given approval to utilise unused prison buildings in Cooma, approximately 400 kilometres south of Sydney (McDonald 1973:11). Manning believed that close proximity to family members would facilitate the residents' recovery by encouraging more frequent visits of family and friends. The 64 males housed in Cooma had relatives living in the surrounding district. By 1884, the temporary asylum was closed because Cooma's isolation, in particular its distance from Sydney, made it an unviable proposition, in both administrative and economic terms. In the meantime, Manning had inspected a potential site for an asylum at the Kenmore Estate, approximately 200 kilometres north of Cooma and five kilometres northeast of Goulburn. The Estate was described in a report of the Parliamentary Standing Committee on Public Works as:

> (f)airly well sheltered by a range of hills and park-like and pretty; the outlook from it, ... picturesque; and its situation – undoubtedly healthy. (McDonald 1973:12)

Manning's argument, that enough Sydney patients to constitute a new asylum came from the Goulburn district, was a factor in his successful lobbying of the NSW Government. The other advantage of the Kenmore site was its close proximity to the railway. The NSW government purchased 348 acres of land in 1879 and funds and building approval were given for the construction of the Kenmore Hospital in 1893 and 1894 respectively.

The construction of Kenmore Hospital was complete by 1900, with the exception of convalescent wards, reception wards, nurses' homes, the Lunacy Court and Lunacy Administration Office, which were built in the early decades of the twentieth century. The first patient, a transfer from another asylum, arrived in Kenmore in 1895. By the end of that year Kenmore accommodated 146 male patients. The first female patient arrived in 1897[45] and direct admissions to the asylum commenced in the same year (McDonald 1973:21).

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[43] Leoné Morgan, *Museum Musings*, Kenmore Hospital Museum, Issue No. 8, February 2005.

[44] This title was altered in 1918 to the Inspector-General of Mental Hospitals (http://investigator.records.nsw.gov.au/Details, accessed 20 May 2004).

[45] Leoné Morgan, undated paper.

Just over a decade after Kenmore was in a position to receive direct admissions, the Federal Capital Territory[46] was proclaimed at Canberra, and building commenced two years' later, in 1913. The history of white settlement in the region had begun in the 1820s when the first blocks of land were made available by government for purchase by cattle and sheep farmers (Fitzhardinge 1954). By 1911, Canberra had a population of 1,921. Ninety years later, approximately 180 years after European settlement, the population had grown to 307,053 (Australian Bureau of Statistics 2003:1).

The ACT is a heart-shaped area of 2,357km2 situated in the centre of the Southern Monaro tablelands, with the city of Canberra constructed towards its northern boundaries (Denning 1944:13). Lying 655 kilometres north of Melbourne, Victoria and 307 kilometres south of Sydney, NSW, the two contenders for capital city status, Canberra was viewed as a neutral choice and a compromise between the two states.

Canberra's design was based on an outcome of an international competition that was won by Chicago-based architect Walter Burley Griffin. Griffin drew a plan for the nation's capital that incorporated 'great boulevards - tree-lined avenues' to link the city's national institutions (Denning 1944:17). Over time, Canberra developed as:

> a series of towns ... linked by an efficient freeway system. Each town consists of suburbs ... where a heterogeneity of housing types occur ... neat, modern, well-kept dwellings liberally interspersed with parks and recreational facilities. (Bruen and Hennessy 1975:223)

As a planned city, Canberra's development and growth has been closely connected to and dependent on the economic and political imperatives of government (Denning 1944:18; Daley 1954:37). Its history is generally described as the rise of a town comprised largely of public servants. Its population has accordingly been described as young, educated, transient and in a higher household income bracket in comparison with the demographic profiles of other Australian cities (Bruen and Hennessy 1975:223). By 2001, Canberra had the highest proportion of couples with dependent children of all capital cities in Australia (41.9%); the highest percentage of labour force with a degree or higher qualification (31.1%); and 16.8% of Canberra households were in a high income bracket [weekly income of $2,000 or more] (Australian Bureau of Statistics 2003: 17, 23, 26).

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[46] Later changed to the Australian Capital Territory (ACT).

Canberra's comfortable socioeconomic status was achieved in the second half of the twentieth century. The early stages of Canberra's development, undertaken in several waves of government expansion, were decades of struggle. Each influx of public servants created pressures to construct the physical and social landscapes in which to accommodate them. In 1927, the year in which Parliament House was opened, Canberra consisted of little more than 'red mud and raw timber shanties, an outback wilderness ... intolerably remote and primitive to many of those forced to be there, the public servants especially, most of whom lived comfortably anchored to Melbourne, the interim seat of Federal government' (Slessor 1966: 21). It was into this 'outback wilderness' that Melbourne public servants started arriving from early 1927 onwards:

> laughing, weeping, jeering, or silent, resigned, apathetic, the procession poured in ... (to) a silent valley mocking the efforts of men, symbolised in small settlements and public buildings striving to attain a grotesque dignity. .... (with houses jutting) churlishly out of the red, raw earth... and sheep-dung ... (telling) only too eloquently of a prior tenancy. (Denning 1944:30)

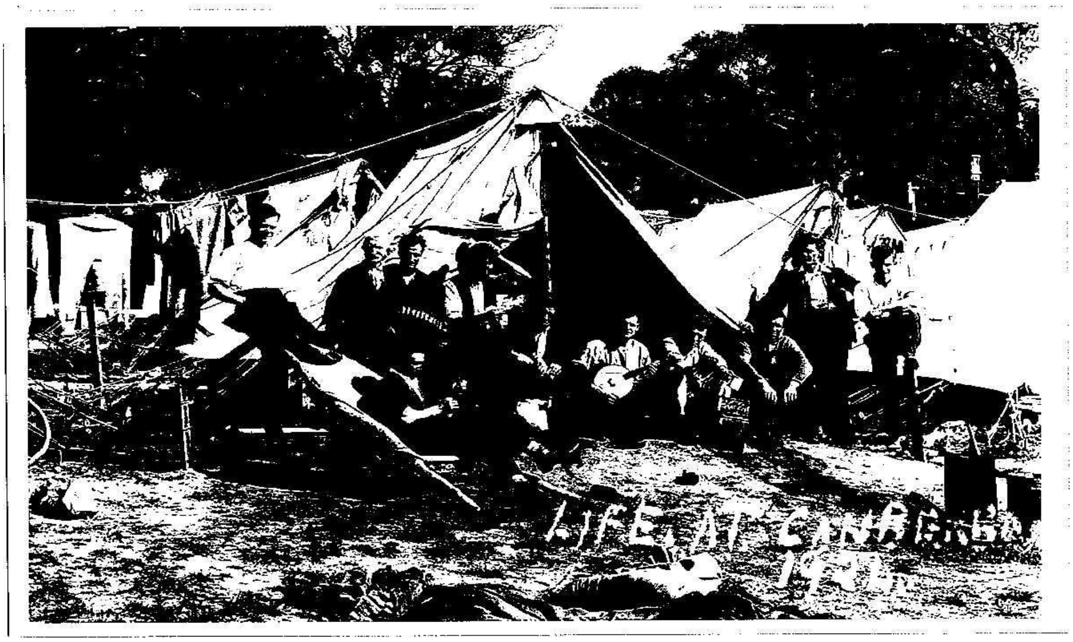

Plate 6. Canberra construction camp, 1924
Photo courtesy of Canberra District Historical Society

The building and construction employees lived and worked in rough conditions. Of a total population estimated at 5,736:

> some 3000 were construction workers who lived in camps and temporary housing settlements all over the city, ranging from tents, through ramshackle huts of various sorts to neat, standardised wooden cottages. At the bottom of the pile were the itinerant labourers without family ties who drifted in and out of employment, lived hard in the poorest accommodation, often drank hard and depended for their livelihood on the whims of those in authority. ... The building workers had every reason to be jealous of public servants transferred from Melbourne, who had been settled at once into houses which, if not always well designed and built, were at least substantial. (Gibbney 1986:8).

After the opening of Parliament House, employment opportunities declined and by 1929, Canberra's building efforts were postponed as a consequence of the economic constraints of the Depression (Daley 1954:42; Denning 1944:49). Despite the lack of employment opportunities, unemployed men continued to arrive, many of whom stayed, existing on 'official sustenance work, occasional casual jobs, and sometimes by begging around the suburbs, and living in official camps ... and in more primitive private encampments tucked away on the river flats or in some of the many plantations around the city' (Gibbney 1986:31-32). With the onset of World War II, plans for the transfer of the remaining 50% of government departments from Melbourne to Canberra were deferred, and the existing Department of Works relocated its operations to Melbourne (Gibbney 1986:33).

A second major wave of government expansion occurred post World War II, resulting in an influx of migrants from interstate and overseas. In 1947, only 4,824 of Canberra's 16,900 residents had been born there (Borrie 1954:224). In the same year, public servants represented the single largest group of workers, at approximately 52%. The second largest occupational group, of 19%, was the building and construction workers (Spate 1954:228). While public servants tended to be Australians from other states, building and construction workers were more likely to be overseas born immigrants (Borrie 1954:225). York notes that the majority of these overseas immigrants came from English speaking countries. By 1954, though, in the context of the national 'populate or perish' program of selective mass migration, European immigrant numbers had increased significantly, from 117 in 1947 to 5,006 in 1954 (Jupp 2002:6,10; York 1989:5).

Much of Canberra's published histories tend to present nostalgic stories of pioneer settlement in a growing community, of families conquering adversity in the face of daily hardships. A lesser-known history, though, comes from the stories of those residents who did not adjust and who were subsequently rejected by the Canberra community. Many of the newly arrived were living without family support. While conditions had improved since the ‘outback wilderness’ of the 1920s, migrants continued to encounter difficulties in finding appropriate accommodation. Single males, in particular manual labourers from overseas, Displaced Persons, and returned soldiers did not fit comfortably into the Canberra community. At the same time, the overweening influence of public servants created a middle-class culture of high expectations and social competitiveness among residents. In the survey findings of approximately 1,500 Canberrans conducted in 1971, Bruen and Hennessy note the difficulties for those persons ‘living on a low income in a high income community’ (Bruen and Hennessy 1975:229). Some of Canberra’s residents did not manage to conquer the challenges of living in Canberra and were driven mad, bad or sad in the making of the Nation’s Capital. Their stories are discussed in Section 4. In the chapters that follow, I describe the physical and social landscapes of care of Canberra’s residents, in both the asylum and the community.

6. The Moral Architecture of the Asylum

The spreading fields lie all around
The hills with verdant green are growed:
And where the Wollondilly flows
The drooping weeping willow glows
Dear home of rest in old Kenmore
Where welcome smiles from every door
Where even nature finds retreat
And stricken men find solace sweet
(Joe Kay, Goulburn Evening Post, 15 June 1942, cited in Condé [undated])

The relationship of the above author to Kenmore is unknown. It is possible that Kay was a returned soldier who received treatment and care at the 114th General Hospital, as Kenmore was referred to during its takeover by the Australian Army takeover during 1942-45. The excerpt from Kay's poem depicts Kenmore as a 'home' where men could find 'solace' for their experiences of World War II. This romanticised representation of the asylum may have resonated with the experiences of some of the returned soldiers who spent time at the 114th General Hospital. In view of the action they had endured prior to their admission, the asylum may well have provided a form of retreat.

This chapter explores some of the contradictory roles of the asylum by examining how the dynamics of care were realised through the form and function of Kenmore's 'moral architecture'. In using this term I draw on Edginton's study of the moral architecture of the York Retreat. Edginton describes the therapeutic role of the environment 'to create a refuge for the mind to heal itself within a proper atmosphere' that was articulated by the Tuke family in the Retreat's design and construction (Edginton 2003:103-4). The Tukes' vision was to create 'an architecture of caring' that provided a family-like, orderly, cheerful setting close to nature that positively affected the recovery outcomes of its insane inhabitants (Edginton 2003:107). Orderliness was achieved through classification and gender segregation. The subsequent therapeutic successes of the Retreat were responsible for the adoption of its design principles in the construction of purpose-built asylums in Europe and North America from the 1850s onwards (Edginton 1988, 1994; Gittins 1998:17).

The following description and analysis of the asylum's 'form' and 'function' compare them with a therapeutic vision for the environment as exemplified by the Retreat's moral architecture (Edginton 2003). Kenmore, however, was not a static landscape. Accordingly, I illustrate how over time its moral architecture was shaped by the Herd Care and Therapeutic Community regimes. I also consider the different ways in which the moral architecture of the asylum was modified in response to the political and fiscal priorities of government.

Psychiatry and architecture: building a moral environment

Kenmore's buildings, representative of the pavilion system of asylum design, consisted of 'wards stretching in a V-formation towards the (Wollondilly) river' (McDonald 1973:18):

> During the last five years a handsome pile of buildings has been steadily growing up on the banks of the Wollondilly River, ... The visitor to Kenmore is always struck with the almost lavish expenditure of money as evidenced in the handsome buildings and their splendid appointments for the comfort and convenience of both the patients and staff. (Goulburn Evening Penny Post [undated], cited in McDonald 1973:19).

In a Report presented by Manning's successor in 1900, Kenmore is described as 'the pioneer in the policy' of Manning (McDonald 1973:22). This comment relates not only to Manning's successful lobbying of the NSW Government but also to his input into Kenmore's location and design. The Government Architect, Walter Liberty Vernon, designed Kenmore Hospital under instructions from Manning. The collaborative relationship between these representatives of psychiatry and architecture ensured that a knowledge of insanity was incorporated within Kenmore's design. Vernon and Manning jointly prepared a report setting out a list of design specifications for Kenmore similar to those of the Illinois Hospital for the Insane, Craig House, Morning Side, Edinburgh, and recent additions to the Sunbury Asylum, Victoria.[47]

Kenmore exemplified the nineteenth-century asylum design principle of treatment through environment (Edginton 1994:379). It was constructed to accommodate a maximum of 800 residents. The English pavilion system of asylum design was modified in the Australian setting: Kerr notes that while some features remained the same – 'administration, dining, kitchen and allied facilities were on the axis and accommodation extended symmetrically on each side' – the Australian version added a design feature whereby 'pavilions were set within their own airing grounds and were linked by covered ways' (Kerr 1988:124). Central to the recommendations of the *Joint Report of the Inspector-General for the*

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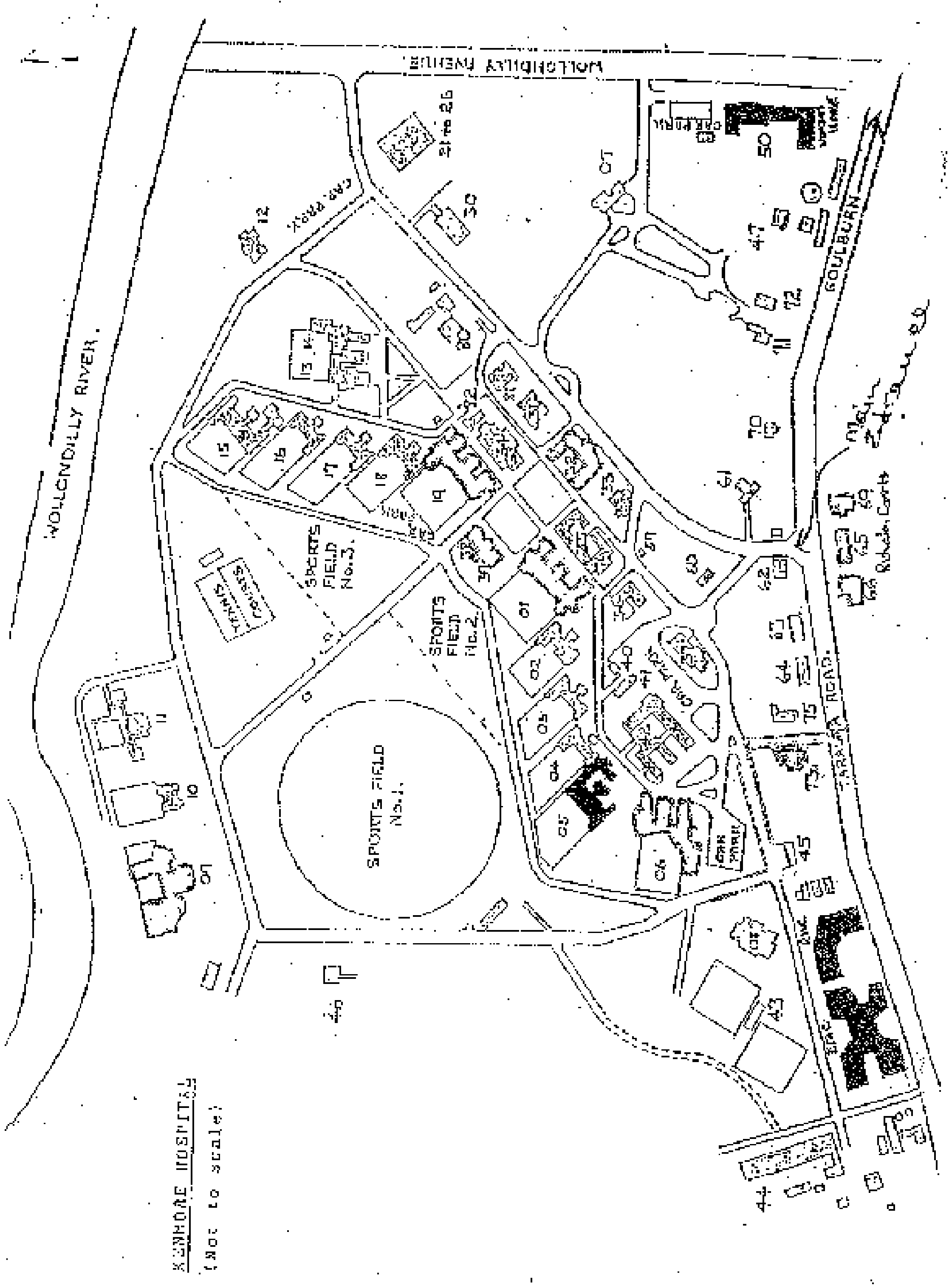
[47] *Joint Report of the Inspector-General for the Insane and the Government Architect, 31March 1892. Particulars for a Hospital for the Insane at Kenmore, Goulburn.*

Plate 7: Kenmore Hospital Map[48]



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[48] Map provided by Leonè Morgan

Insane and the Government Architect was the desirability of an institutional geography ordered by gender and capacity for autonomy, and this is reflected, firstly, in the division of gender on either side of the axis - the Joint Report notes that ‘accommodation for male and female patients should be kept distinct on either side of the centre so as to admit of complete separation’ - and secondly, in ward classification.[49]

Diagnosis and capacity for autonomy determined one’s placement in wards. Kenmore’s ward system was similar to that practiced at the Retreat and most nineteenth-century asylums. At the time, Samuel Tuke explained this logic as follows:

> those who are violent, require to be separated from the more tranquil, and to be prevented by some means, from offensive conduct, towards their fellow-sufferers. Hence, the patients are arranged into classes, as much as may be, according to the degree in which they approach to rational or orderly conduct. (Tuke 1975:136)

This logic was implemented by a standard asylum procedure, described by Elder as identification, division and segregation of:

> the curable and the incurable; the calm and the agitated; the obedient and the non-submissive; those capable and those incapable of working; those to be punished or left alone; and the level of surveillance required. (Elder 2006:57-58)

The potential for patients’ rehabilitation was thus built into Kenmore’s architecture. For example, the spaces of the Quiet and Industrious wards were available for those residents deemed ready for the most liberal forms of care. The built environment of these wards reflected their residents’ readiness for freedom, for example, in the absence of the ha-ha wall, a permanent feature of other wards.[50] In his visit to Kenmore in 1926, the Inspector-General of Mental Hospitals reports on the male Quiet and Industrious Ward as follows:

> The grounds are not enclosed either by fences or by a ha-ha and mark a great advance towards removing restrictions from those patients who can be trusted.

Apart from sex and capacity, the asylum did not formally observe other differences such as ethnicity or social standing. Each ward, then, was a microcosm of social diversity, and its structural cohesiveness was ideally derived from the residents’ capacities for autonomous behaviour. Original ward

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[49] Inmates were physically divided up and segregated according to sex not only to enforce the norms of moral conduct but also to limit their reproductive capacities (Gittins 1998:19). Gender separation, as reflected in Kenmore’s design, was further reinforced by employing female staff to care for female patients, and male staff to care for male patients.

[50] Kerr describes the ha-ha as ‘a device popular in eighteenth century English country estates which provided a barrier to stock but did not interrupt the view - .... It was achieved by the simple expedient of sinking a wall out of sight in a trench and was supposed to have been named after the surprised ejaculation forced from a guest’s lips on discovering that the seeming continuity of sward was a deception’ (Kerr 1988:158).

classifications such as the 'Recent and Acute', the 'Violent and Noisy', the 'Intermediate', and the 'Quiet and Industrious', constructed a hierarchy of capacity through which the resident could progress. The wards also represented a continuum of different levels of staff surveillance that correlated with this classification scheme.

While it was the ideal, subsequently, in overcrowded asylum conditions, this classification system was not always achieved. Furthermore, following a governmental preference for *lumping*[51] them together, the *multicultural* constituencies of Kenmore, including the psychotics, inebriates, epileptics, geriatrics and retards, shared ward space much to the dismay of the various incarnations of the NSW Inspector-General of Mental Hospitals.[52]

Additional specifications, as set out in the Joint Report, provide further elaborations on how psychiatric conceptions of patients' capacity for rational conduct informed building design. Thus, wards 'for the industrious patients should be near the workshops for males, and near the laundry for female patients'. And within these wards 'for violent and noisy, and for recent and acute cases, the proportion of single rooms should be about one-half, and there should be provision for special padded or panelled rooms. In the sick wards the proportion of single rooms may be less, and in those for convalescent and chronic cases comparatively few are requisite' (Inspector-General and Government Architect 1892).

Recreation and activities are essential techniques of moral treatment and the Recreation Hall was thus constructed in a central location and 'so arranged as to serve for Divine Service as well as recreative gatherings'. It was used as a chapel, a cinema, a dance hall, and as a venue for theatre. Being mindful of residents' diagnostic conditions, Manning recommended that '(d)ressing and retiring rooms were provided as well as small rooms or lobbies near the door, to which epileptic patients may be removed if seized with fits' (Inspector-General and Government Architect 1892).

As mentioned elsewhere, the Retreat was designed in such a way as to reflect a family like living environment. Kenmore was built with a larger population in mind. Institutional order was privileged over family like living: 'buildings, though containing every requisite for the proper treatment of the

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[51] Porter 1990:49.

[52] See Chapter 11 for an elaboration of Kenmore's 'multiculturalism'.

insane, should be simple in construction and without ornament' (Inspector-General and Government Architect 1892). However, the Retreat's ethos of home style accommodation as a form of therapy was included within aspects of Kenmore's architecture: 'detached houses or blocks should be so planned as to resemble large private houses, both inside and out, as far as possible' (Inspector-General and Government Architect 1892). Central to the theme of family like living was the Medical Superintendent's residence, whose size and grandeur symbolised his leading role in the asylum as patriarch.

The estate of Kenmore had been selected by Manning because of its quiet, picturesque, rural location with views across and access to the Wollondilly River. Nature was believed to have a powerful effect in the recovery and restoration of sanity: '(t)he curative power of pure, romantic nature itself ... was called into service. Nature was to heal insanity like all the other problems caused by chaotic social progress' (Doerner, cited in Edgington 1997:95). In line with Tuke's vision, Manning recommended that inmates be able to enjoy the calming and healing properties of nature: '(t)he buildings should, as far as possible, front in a northerly direction, and should be so placed as to allow an uninterrupted view of the surrounding country from the principal rooms' (Inspector-General and Government Architect 1892). Airing courts, to be provided for each ward, block, or house, would give inmates the opportunity to wander within a confined space outside the buildings.[53]

An uneasy space between a prison and a hospital

Markus writes that the architectural features of asylums occupy 'an unstable place between prison and hospital', of 'individual, solitary cells' and the ward system that is 'a unique space which is locally free but securely bounded ...' (Markus 1993:130).[54] Institutions for the insane in the convict settlements of New South Wales in the early 1800s utilised lockups or gaols for the confinement of those diagnosed or described as mad. Prior to the opening of New South Wales' first lunatic asylum in 1811, the mad tended to be mainly convicts, and their confinement in these institutions was deemed to be an appropriate solution to their

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[53] Another example of Manning's consideration of the psychological sensibilities of Kenmore's inmates was his stipulation that the mortuary be located 'as much as possible out of sight of the general wards'.

[54] Similarly, Prestwich describes how the involuntary and the voluntary admission pathway mobilised different discourses of the asylum as hospital and as prison (Prestwich 1994); and de la Cour describes patients' perceptions of the asylum as a 'prison' (de la Cour 1997).

necessary segregation from the community (Garton 1988:17). During the course of the nineteenth century, while the terminology and practices for governing the insane evolved in line with treating madness as a disease or illness, the architectural designs of asylums symbolised the enduring governmental requirements of segregation and confinement alongside treatment and care.

Intrinsic to the principles of moral treatment, however, was the view that visible reminders of inmates' imprisonment could impede their healing and recovery (Markus 1993:135). Where possible, these reminders were minimised. For example, the iron sash bars that reinforced the Retreat's windows were covered in wood (Digby 1985:55; Markus 1993:135). At the same time, the holding institution remained an environment of 'locked living units' and 'locked areas within living units' (Wolfensberger 1975:8-10). One way of understanding how the oppositional roles of prison and hospital were inscribed within the asylum's form and function is by analysing the meanings and practices associated with three dominant symbols, the key, the ha-ha and the single room.

The key symbolises the asylum's custodial responsibilities and capacities. In interviews and group discussions with former nurses, it became obvious that an understanding of the role and use of the key was essential for understanding the structure of their daily routines and responsibilities. While Kenmore's records did not include files on its administration procedures, the early to mid twentieth-century Register index cards relating to provisions for the Royal Derwent Hospital, Tasmania did provide an understanding into some of the intricate ways in which the key pervaded asylum knowledge and routines, which may be generalised for Australian asylums in that period.[55] The entries listed under the heading of Lock and Keys imply that the key played an important role in maintaining asylum order and security:

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[55] An informal comparison between Australian twentieth-century asylum administration procedures, in particular those for NSW, Tasmania and Victoria, suggest that they were fairly uniform across state and territories. Coleborne also noted similarities in aspects of administrative practice in New South Wales, Queensland, Victoria, and New Zealand colonial asylums (personal communication).

> 17/1/24 Forwarding sample female key.
> 3/4/24 Advising forwarding 24 locks for repair
> 15/1/26 Requesting to complete repairs to 76 padlocks – 33 mortice grey locks
> 19/2/26 Advising re return of 1 gross of sleeve locks as they were not made as per sample forwarded, and requesting make another gross as per sample and treat matter as urgent.
> 6/9/37 Order for repairs lock in Rooms 63, 68.
> 13/10/37 Advise forward 12 locks repaired and enclose claim by Jacksons.
> 20/12/37 Advise forward sample lock and also that last order received from C Davis.
> 8/8/38 Instruct to impress on staff necessity for closing doors carefully.
> 29/9/38 Instruct to furnish explanation re keys broken in division.
> 29/6/39 Request to expedite supply of Universal Locks.
> 11/9/39 Jacksons advise forward 12 male and female keys.
> 29/11/40 Forward sample key for sleeve locks.[56]

While the dates listed under the entry for Lock and Keys do not represent a complete record for the period covered, they do give some insight into how the key structured asylum routines. The entries also remind the reader of the ways in which the key links the physical environment with social practice.

The rituals encompassing the turning of the key, whereby inmates were segregated, treated, disciplined, and confined, evolved in accordance with and in response to the policies of Herd Care and Therapeutic Community. The transition between the two care regimes, from *locked door* to *open door* practices, was messy and never complete because *you'd select which doors you should open – you wouldn't open the doors of patients who were impossible* (Sandy, who commenced working in Kenmore in the 1960s).

Central to understanding the enduring role of the key is the fluctuating and contingent binary opposition of in/out. In her analysis of the symbolic meanings of the asylum gate, Gittins draws on a series of binary oppositions:

> A gate marks a boundary between two worlds: familiar and strange, outside and inside, seen and unseen, mad and sane (Gittins 1998:29).

Binary oppositions were also used by Kenmore nurses to describe the meanings associated with the key, of safety and danger, and the acts of keeping people and objects in or out through the turning of the key:

> *You'd put them in at night time and then you'd turn the key on them, right? You kept them out, out of harm's way.* (Roger, who commenced working at Kenmore in the 1950s)

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[56] HSD272, Archives Office of Tasmania

Nurses described how the key was turned by its keepers in accordance with formal asylum regulations and informal micro dynamics on whom or what should be kept *in* or *out* of specified areas:

> *Well, at one stage, all doors were locked. You know, people were sort of moved from one living area to another. And your outdoor, outside locked doors, your boundary doors were locked. You see, ... you were given three keys, and one key was for your boundary doors, one was for your inside doors, and one was cupboard doors, a square lock for cupboard doors*.[57]

Linda commenced working at Kenmore in the 1960s, and her reflection on the rituals for the turning of the key demonstrates that some aspects of Herd Care were sustained beyond 1958.

While on duty, nurses kept the set of three keys securely fastened around their waists. One key was used to lock knives *in* a cupboard and *out* of reach of inmates. At specified intervals and in certain contexts, the second key would lock inmates *in* or *out* of the various inside ward sections, including the dormitory, the day room and the seclusion rooms. The third key was used to lock outside doors, keeping inmates *in* and the community *out*. The community was viewed as a potential threat because:

> *you wouldn't know who was around – people came for lots of different reasons, some wanted to steal, some wanted to look, some wanted to goodness knows what, ... you just locked the door at night for the same reason you do at home. You know, you kept the outside out and ... the inside in.* (Linda)

These reflections by Roger and Linda (above) on the need to keep residents 'protected' from the community are interesting when one compares them with wide-spread community perceptions of the asylum as a holding institution to keep the community safe from irrational, immoral, unpredictable, and/or potentially violent inmates.

The rituals relating to the turning of the key not only divided up people and objects between *in* and *out* spaces. For example, the highly ritualised asylum inspection performed by the Medical Superintendent and/or Matron, referred to by nursing staff as *doing the rounds*, maintained asylum order not only over the residents but also over the staff. During the course of the rounds, nurses were required to use their keys to unlock and lock doors at appropriate intervals:

> *Like, if she (the Matron) came through the top, if you're in Female 3, she might have started in Female 2 and gone downstairs and come up the stairs along the*

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[57] I personally experienced the different locking spaces of the ward in the course of fieldwork in the former Male Ward 1 at Kenmore, which is now the repository of medical records. The boundary doors had inadvertently been locked by a worker. I made this discovery after I had locked myself out of the main records area. I was, in effect, confined to the space between the boundary and the inside doors.

> *dormitory and then there was a walkway into 3. She comes through there – one nurse would be at the door, with her hands behind her back, ... and you had the key in the door, open for her, and as soon as she went through you locked your door. The next girl had another position, and another door.* (Brenda, who commenced work at Kenmore in the 1940s)

The rituals of the key were at times subverted by staff who resisted managerial attempts in securing their compliance. Their contravention of the rules associated with the *square box* is an example of staff resistance. The *square box* was situated in Male Ward 4. The inmates of this ward were classified as *noisy and violent* or *refractory*. It was believed that this category of resident required vigilant surveillance. Nurses were routinely monitored by asylum administrators to ensure that they undertook this surveillance: Kenmore installed a square box which, in the course of the night shift had to be turned by a key by nurses every 15 minutes, a signal that they were performing surveillance of the ward. Nurses subverted this rule by offering payment to ward workers or *trusties*, usually in the form of cigarettes, to turn the key for the *square box*.

The key thus symbolises an enduring managerial tactic of the asylum for reinforcing the ruling norms of order, hierarchy and classification. The layered meanings embedded within the rituals associated with the turning of the key are encompassed within the binary opposition of *in/out* which orders and classifies inmates according to their needs for protection from themselves, each other and the community, and the asylum's responsibilities for maintaining safety, controlling for dangerousness and other problematic behaviour.

In addition to its custodial symbolism, the ha-ha wall provides an example of the asylum's restorative role. Manning and Vernon resolved the enduring tension between confinement and restoration by recommending that 'boundary walls or fences be sunk in a ha-ha so as to allow of an uninterrupted view' of the surrounding hills (Inspector-General and Government Architect 1892). The ha-ha represents the asylum's changing beliefs on therapy and care through its negotiation of the dynamics of care. During the Herd Care era, the ha-ha walls of Kenmore's airing courts permitted an unrestricted view of nature and the promise of freedom, while keeping inmates securely confined. Subsequent to the introduction of liberal care practices of Therapeutic Community, however, the ditch was filled in, giving more residents a greater freedom of movement on the asylum's grounds.

Plate 8: Ha-Ha Wall, Kenmore Hospital 2005 Photo: D Kordes

The different uses given to the seclusion room are symbolic, not only of the asylum's enduring roles of repression and rehabilitation, but how they were mediated in a physical setting. Violent or manic inmates, those unresponsive to medication, would spend periods of time locked up in the seclusion room, while other inmates were allocated the room as a reward for being *tidy and clean* or for being a *worker*. In this context, it was referred to as a *single room* and turned into *nice bedrooms for those most able to look after them* (Linda).

In both the Herd Care and the Therapeutic Community eras, the single room could therefore be used as either a punishment or a reward. The single room could symbolise residents' autonomy, privilege and privacy or alternatively, in the case of *violent patients,* their lack of autonomy and the need for punishment and seclusion. Intrinsic to understanding how these meanings were mobilised is the voluntariness or otherwise associated with the single room. Privacy has been described as a privilege and status that is also connected to western understandings of autonomy (Lidz *et al* 1992:142). Lidz *et al* observe that analysing the allocation of privacy rights in institutional settings may provide insights into the attribution of autonomy among its inhabitants. Depending on ward numbers and the relationships between nurses and their charges, single rooms were given to workers or *trusties*.[58] These were asylum residents whose behaviour had earned them the right, however conditional it may have been, to some privacy. His or her attributed capacities for autonomy could therefore determine whether the ward resident had the freedom to open/close the door of a furnished single room or was confined in a seclusion room, the small mat and black rubber basin symbolic of his/her diminished autonomy.

The industrious asylum

In common with other asylums in Europe and North America, NSW asylums were encouraged to become as self-sufficient as their grounds permitted. As part of residents' recovery process as well as to offset the costs of their maintenance, Kenmore was set up to become a self-sufficient institution. A working farm was established, including the erection of 'cow-byres for 35 cows, extensive piggeries, forage stores, root stores, boiling rooms, milk rooms, lofts, enclosed yards, etc. which cover an area of about 17,000 feet' (*Parliamentary Debates* Volume 82, page 701, cited in McDonald 1973:20). Various workshops were constructed. Jobs were mainly allocated according to gender. Males were engaged in the activities of workshops for carpenters, painters, tailors, plumbers, blacksmiths, mattress-makers and upholsterers, and bookbinders. The cutting-out room, sewing room and mattressing room were deemed as work spaces suitable for females.

Throughout the files of correspondence between the Inspector-General and asylum Medical Superintendents are references to topics that appear to be more appropriate for the running of rural communities and working farms than psychiatric institutions. Domestic concerns such as problems with septic tanks and white ants were topics of frequent discussion. Job advertisements relating to farming activities, for example, the position of Dairy Inspector, were not unusual. Medical Superintendents would occasionally seek approval from the Inspector-General for the purchase of bulls. On occasion, discussions would take place on the merits of certain 'Cow Foods'. In 1935, in a letter from a medical superintendent to the Inspector-General, the death of Hector the Horse was announced:

> At this horse's age, 25 years, it is not unusual for them to die suddenly, and it was not considered necessary to hold a post-mortem examination, or to report the matter to the Stock Department.

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[58] This is discussed at greater length in Chapter 9.

In addition to addressing managerial concerns of farming and building maintenance, a sense of community, overseen by the Inspector-General, was promoted between asylums. Asylums were of themselves ‘closed communities’ of a certain kind, each governed by the patriarchal figure of a Medical Superintendent. They also formed part of the wider NSW asylum family, over which the Inspector-General presided. A wide array of sporting competitions between asylums, meriting announcement in correspondence between the Inspector-General and Medical Superintendents, may have contributed to building a sense of belonging to this family. Sporting events not only fostered a sense of community of shared interests. They were also justified on the basis that they provided a recreational activity for inmates, as participant observers.

An aspect of moral treatment promoted by the Retreat was the use of animals in residents’ recovery process. The Retreat staff encouraged residents to interact with rabbits, sea-gulls, hawks and poultry in the exercise yards (Markus 1993:13). In NSW, the calming and civilising spectacle of exotic or native animals within asylums’ grounds was also creative of a competitive spirit amongst Medical Superintendents. At one period of its history, Callan Park stocked alpaca ‘to divert and, perhaps, inspire the patients’ while Gladesville opted for native animals such as echidna and wallaroo (Kerr 1988:127). Kenmore also participated in this ‘modest competitiveness’: one of its Medical Superintendents kept a Himalayan bear ‘to entertain his patients’ (Kerr 1988:127). As a reminder of the personal and professional visions of this man of psychiatry, the bamboo that was once grown for the bear continues to thrive in Kenmore’s grounds to this day.

The use of exotic animals, supposedly for their therapeutic benefits for inmates, suggests that the Medical Superintendents at times resorted to flamboyant and eccentric treatments that reinforced their own self-identification as psychiatric heroes (Robson 2000:2). A benign example of their eccentricity provided by nursing staff was the tale of a former Medical Superintendent of Kenmore who commandeered the role of train driver in the transportation of approximately 1,000 asylum inmates for an outing in the Goulburn district. Certainly, the position of the Medical Superintendent was at the pinnacle of the asylum hierarchy. He was ‘physician, judge, father and teacher’ (Engstrom, 2003:1; Barrett 1996:181), and the formal authority vested in him legitimised his reign over the asylum as *God* or at the very least, as ‘feudal lord’ (Robson

2002:69; Gittins 1998:31). These patriarchs of the asylum were, however, ultimately accountable to the Inspector-General.[59] And at an implicit level, the regular interactions and communications between NSW asylums served to encourage the reproduction and reinforcement of organisational cohesiveness, conformity and accountability to legal and administrative regulations and procedures of which the Medical Superintendents were regularly reminded in writing by the office of the Inspector-General.

The asylum of the Herd Care era

One of the responsibilities of the office of the Inspector-General was to inspect all formally approved facilities for the insane. A reading of his reports of visits to Kenmore suggests that, while the asylum's original design reflects a commitment to providing inmates with an environment conducive to their recovery, this moral purpose was at times subverted by the mundane routines of the asylum. Kenmore's buildings and grounds formed part of an evolving, dynamic environment in which the patients and staff were engaged in ways not always foreseen by Manning and Vernon. In his 1931 report, for example, the Inspector-General makes reference to the undesirability of permitting night nurses to use the single rooms in wards that had originally been designated for patients' use. And while Kenmore's formal design was symbolic of a moral architecture that effectively segregated the sexes, in practice this ordering scheme was at times contested by both staff and patients. In the same report, the Inspector-General writes:

> On 16.4.28 it was noted that there were three male patients working in the female wards with a gardener, and that one patient occasionally works in the female wards with an artisan. Four male patients also work around the female wards who were under no supervision.
> On 30.9.29 attention was called to the patients working on the female side with Attendant Kelly, and to those working in the female wards with an artisan. Six patients were also working around the female wards under no supervision.

Once the asylum became populated with inmates, flaws in Kenmore's moral architecture became apparent. For example, the issue of appropriate lighting as a means of providing a cheerful environment in Female Ward 1:

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[59] The Inspector-General's role included (but was not limited to) visiting and inspecting asylums and medical records, making enquiries about residents' treatment and care, authorising transfers of inmates and reporting to government (http://investigator.records.nsw.gov.au/Details, accessed 20 May 2004).

> On 28th October, 1926, attention was again called to the necessary modification of the wooden partition between the Day and Dining Rooms to give better lighting, ...
> On 18th January, 1927, attention was for the third time called to the modification of the wooden partition between the Day and Dining Rooms with the object of providing better lighting effects.
> On 22nd March, 1927, attention was again called to the condition of the wooden partition between the day and the dining room.
> On 9th September, 1927, the bad condition of lighting in the day and dining room was again referred to.
> On 4th January, 1928, ... Although some alteration had been made in the wooden partition between the day and the dining rooms it was pointed out that this was not sufficient and that more glass was still necessary in the wooden partition in order to furnish the degree of lighting which appeared to be necessary. (emphasis in original)

Another recommendation for the modification of existing structures concerned the lack of privacy for female patients. Throughout the 1920s and 1930s, reports prepared by the Inspector-General consistently refer to the desirability of providing privacy for certain patients. In 1926, for example, he recommended the following modifications for female residents of the Sick and Infirm Ward:

> (M)ore privacy for patients could be obtained by putting a half swinging door in front of the WC.
> the advantage of having a special room for undressing is stressed together with screens for the use of those patients who require privacy and also in the bathroom, the advantage of trying to provide privacy for those patients who prefer to have their sprays in privacy is well worth the consideration of the Hospital.

The Inspector-General's recommendations for patient privacy were not implemented until the late 1960s. Margaret recalled the image of patients bathing without privacy in the Herd Care era. Her first day at Kenmore took place on a cold winter morning in the 1940s. She had been assigned to a ward with a large proportion of geriatric inmates and was confronted by the sight of old naked women lined up outside the bathroom - a line that ended in the outside yard - waiting patiently for their group showers.

The constant wear and tear on asylum buildings posed challenges for building upkeep and maintenance. In a 1931 report, the Inspector-General writes:

> On 28.10.26 it was pointed out that the Amusement Hall and the Sewing Room were badly in want of painting.

This painting work was still outstanding in 1931. In the same report, he notes the conditions in Female Ward 2, a ward for the Recent and the Acute:

> The airing court of this ward which is occupied by destructive patients was disappointing in its appearance … an almost complete absence of brightening by shrubs, and the brick walls were discoloured and shabby looking.
> On 27th February 1926, ... The single rooms were commented upon. <u>The urgent need of painting was pointed out, and although these are occupied by very dirty and destructive patients it should be possible by constant attention and painting to relieve them from the atmosphere of disrepair and unattractiveness which exists</u>. (emphasis in original)

In his Annual Reports prepared for the NSW Legislative Assembly the Inspector-General described Kenmore's conditions in more positive terms. For example, in his 1938 Report, the asylum's work, of introducing new recreational and work activities and maintaining a cheerful environment, is commended:

> The institution of an occupational work-room in the Female Admission Building has been a progressive step. A number of suitable patients have become interested in these various activities and are happily occupied, and the quality of the results is an indication of their interest.
> Much has been done to improve the comfort of the inmates of the Reception and Admission Wards. The dormitories and rooms have been repainted in bright and cheerful colours, and, where possible, new furnishings have been provided. No greater mistake is made than to imagine that "anything is good enough for mental patients." ...
> A modern Talking Picture Machine has been installed in the Recreation Hall, thus replacing the older machine. The entertainment provided by the new machine is much appreciated by the patients.

There were, however, certain aspects of asylum conditions which the Inspector-General could not overlook, in particular the problems of overcrowding and lack of government funding. These issues may also explain why some of the recommendations arising out of his visits to Kenmore for ward improvements were not implemented. For the function of environment in effecting recovery and restoration of sanity was consistently undermined by the conditions in which asylums were forced to operate: for much of its history, Kenmore was overcrowded and understaffed, and its buildings and grounds were allowed to become run-down.

The treatment that was built into its architecture could never be fully realised in practice because, like other asylums of its era, Kenmore was constrained by a lack of political will and financial support by government. Correcting the sub-standard living conditions for the irrational, the irresponsible and the unproductive was not a high priority for the government. The moral architecture of NSW asylums was subverted by the fiscal agenda of maintaining order and control over a seemingly disposable population group.

Over the years, the Annual Reports prepared by the office of the Inspector-General of Mental Hospitals and submitted before the NSW Legislative Assembly continued to articulate a knowledge of psychiatric hospital management along therapeutic lines which is reminiscent of Tuke's vision for the Retreat. In his Annual Report for the year ending 30 June 1930, he notes that 'the overcrowding is such as to be detrimental to the treatment the institutions are able to afford, in that the number of rooms for patients who require them are deficient.' In 1934, he writes that the impact of overcrowding on patients constituted:

> a prejudicial effect so far as their recovery is concerned, and also leads to undue frictions between patients. It also imposes unfair burdens on the officers and nursing staff in trying to supply the deficiencies. (p.3)

In 1934, Kenmore, with a resident population of 1,147, was the most overcrowded asylum in NSW, 281 patients in excess of its capacity.

In addition to adversely affecting patients' living conditions and thereby impeding their recovery, overcrowding could impact on patients in other ways. Inmates could, at times, be transferred to other asylums as a way of balancing resident numbers. For these reasons, in 1946 Geoffrey Riley was transferred from Parramatta to Kenmore against his family's wishes and despite the fact his family lived in Sydney. While the medical men were aware of the important role families could play in patients' recovery and discharge, on this occasion managerial concerns took priority over therapeutic considerations.

The 1930s and 1940s were bleak years for NSW asylums and the Annual Reports during this period chronicle how Government spending dropped, from £75 per patient per annum in 1929 to £68 in 1938. At the same time, the average number of residents in NSW asylums rose during this period, from 8,748 in 1929 to 10,802 in 1938.

At times, the frustration and despair that asylum administrators must have felt becomes evident in their writing. In one year, the Inspector-General's draft report was censored by the NSW Department of Public Health. In a memorandum from the Under Secretary in November 1934, the Inspector-General was informed that changes to the wording of his Annual Report were required before it could be presented to the Legislative Assembly. The statement 'The Mental Hospitals are medical institutions and the fact that no provision is made for segregation of tubercular patients is a travesty on medical methods' was changed by removing the underlined section and substituting it with: 'and provision for the proper segregation of tubercular patients is an urgent need.'

In relation to the provision of food for patients, the Inspector-General was ordered to change the wording in his Report as follows: 'With an increase of 215 patients under care and increased prices of commodities, to attempt to keep expenditure this year down to last year's aggregate will [underlined word removed and replaced by 'would'] mean a definite [underlined word removed] shortage of food to the patients, a step which the Department is not prepared to take' [underlined phrase removed and replaced by 'a retrograde step'].'

Similarly, in reference to unsuitable wards at Gladesville Mental Hospital, the ward numbers are deleted, and the sentence: 'That a Mental Hospital in New South Wales should have to admit that conditions such as these exist within its walls is a disgrace to the State and no language is too strong to indict such a state of affairs' was removed. Even with censorship, the description of Gladesville that was eventually submitted to the Legislative Assembly represents an accusation against government policy practice:

> These wards in which many patients are destined to spend their lives have no outlook but merely look on to walls with the sky above. There are no day rooms for the patients and when meals are being prepared in the dining room, the patients are required to be put out on the verandahs where on wet days they are exposed to the weather. These wards are looked upon as a blot on the Department. The Department is supposed to provide medical treatment for sick persons whereas with the facilities provided they are housed under conditions which must lead to their deterioration in every faculty. (p.2)

The Inspector-General's Annual Reports provide insights into the different ways the environment impacted upon residents' care and treatment. The problem of overcrowding, for example, exacerbated the complexities of classification, a key principle informing an ordered, moral environment. It was viewed as undesirable to mix inebriates, epileptics, mental defectives and senile cases with mental patients. This related not only to the stigmatising effects of being detained in an asylum but to the negative influences which the psychiatrically dis-ordered were believed to have on the moral well-being of the other patients. The following excerpts from the Annual Report for 1930 are typical of reports submitted to Government throughout the asylum era:

> The Department is still undertaking the care of inebriates in the Mental Hospitals, and it is regretted that no separate institution has yet been provided. ... it is undesirable to ask inebriates to associate with mental patients indefinitely, and the provision of a separate institution is essential. ...
> It was generally felt that senile cases should rather be in infirmaries than in mental hospitals .... Harmless old persons suffering from senile decay. ...
> The operations of the Department would also appear to justify the establishment of a special colony for epileptics. No separation provision is at present made for this class of patient, and they are required to take their places in the wards of the mental hospitals amongst the insane, where obviously they are at times out of place.

In the case of mental defectives, the Inspector-General consistently argued for the necessity of a Mental Defectives Act in line with other Australian states. It was recommended that the responsibility for those mental defectives 'likely to benefit by instruction in special schools' should rest with the Education Department while mental defectives of a lower class would continue to come under the responsibility of the Department of Mental Hospitals (1930 Annual Report).

The shipping out of Kenmore's inmates, 1942-46

NSW asylums continued to remain overcrowded and under-funded throughout the 1940s. The closure of Kenmore Mental Hospital 1942-46 placed additional pressures on those NSW asylums that were expected to accommodate its 1,150 patients, 200 staff and 73 railway trucks of equipment. The evacuation of Kenmore was described by the Evacuation Officer in a letter dated 1 April 1942 addressed to the Inspector-General of Mental Hospitals as 'the biggest job of its kind ever undertaken in the History of Australia', and subsequently in a report dated 29 May 1942, as 'the largest civil movement ever undertaken in the history of this State, ... likened to the wholesale removal of a country town'.[60]

For the duration of its closure, Kenmore became known as the 114th Australian General Hospital. The asylum environment, under the command of the Army, provided psychiatric care and treatments for returned soldiers. It also provided specialist care for skin conditions, malaria, tuberculosis, and surgical cases. Kenmore was considered a location conducive to the convalescence of returned soldiers (Condé, undated paper, p.1).

The moving in and taking over of Kenmore by the Army provided the asylum with a new source of additional funds and resources to undertake building construction and maintenance as deemed necessary for the provision of general and specialised nursing care of soldiers. The report prepared for the Inspector-General by the Evacuation Officer on 29 May 1942 suggested that any treatment which an ordered, asylum environment could provide had been seriously eroded and undermined by staff neglect and oversight:

> On 27/3/42, the soldiers (working parties) refused to load any further equipment from No. 7 Male Ward on account of its filthy and verminous condition. Their refusal was upheld by ... who placed No. 7 Male Ward out of bounds for all troops. This disorganised our removal of equipment from No. 7 Male Ward. It had

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[60] 12/1412.2 Papers re evacuation of mental hospitals.

> subsequently to be removed, cleaned and fumigated by the outdoor staff. From this ward, 35 mattresses and 40 waterproof sheets were condemned and burned. The complaints were justified as No. 7 Male Ward was in a filthy, neglected and verminous condition. ...
> The Main Kitchen, Butchers shop, Vegetable room and Cooks store rooms were in a filthy condition. Vegetable steamers, jacketted pans and hotpress were covered in grease. The dirt surrounding the hot press contained garden worms. In the whole of my experience in the Department, I have never seen a dirtier kitchen block. The Military authorities complained bitterly about the dirty and neglected condition of this section of the Hospital. …
> The filthy condition of No. 1 Male Ward was commented upon adversely by the Military authorities.
> The provision and general store, also the store basement were in a filthy condition. The Military authorities were not complimentary in their remarks about this section of the Hospital. They also complained about the condition of the boundary fences. They are in a very bad state of repair. ...
> The sewerage system (septic tanks) were also in a bad state of repair and rat infested.

There are several plausible explanations for the run-down conditions of Kenmore. These could relate to the consistently overcrowded, understaffed and under-funded conditions of NSW asylums in general. Another explanation lies in the resistance and hostility expressed by staff and patients to the army takeover. In his letter to the Inspector General, dated 16 June 1942, the Lt Colonel of Australian Army writes:

> We entered this hospital some hours after the last patient had gone. About ten days earlier I was here for several days, when resentment and even hostility was very evident on the part of the staff and the patients, and in addition the town folk.

The disruption to the lives of patients and staff also affected the local area in general in that the families of patients and staff lived in Goulburn and its surrounding districts. The institution of Kenmore was a major employer for the Goulburn region. With the Army takeover, regular access to patients was removed from their families, some of the families of staff faced relocation, and a source of employment was removed from the Goulburn community. It was not unlikely that Kenmore was allowed to become filthy and run-down as a form of passive staff resistance to the Army takeover. The Medical Superintendent, whose authority over patients was summarily removed from him, may also have encouraged resistance. The tensions surrounding the Army takeover, between the Army and the asylum staff, and the evacuation of Kenmore’s patients are highlighted in the Evacuation Officer’s report dated 29 May 1942:

> (p)rior to my arrival at KMH, local meetings of protest had been held, also several deputations to Military authorities and Ministers of the Crown. On my arrival, the officers and staff were bordering on a state of hysteria. The Medical Superintendent deemed me to be insane for ever having conceived the idea of using motor buses as a mode of transport for the patients. He visualised a terrible disaster with loss of life and subsequent public scandal for the Department. He repeatedly urged me to endeavour to persuade you to alter the decision and substitute trains. ... The subsequent success of the bus convoy method of patient transport proved my theory to be correct.

It is interesting to observe how the language of psychopathology was used in the dialogue between the asylum and the military to disparage Kenmore officers and Army personnel.

The Army's evacuation of patients on 25 March 1942 comprised three bus convoys consisting of nine double-decker buses to Orange; ten double-decker buses to Callan Park and Parramatta; and ten double-decker buses to Rydalmere and Gladesville; each convoy accompanied by military lorries containing equipment. Trains were used to carry additional equipment as well as patients (81) deemed not well enough to travel by bus.

The repopulation of Kenmore commenced in February 1946. In comparison with the Army's evacuation, which was conducted over several hours, Kenmore's Admissions Registers reveal that the return of patients was a slow process undertaken over two and a half years. Unlike the Army's takeover in 1942, it appears that this time the administrative wishes of Kenmore's Medical Superintendent were given precedence. Buses arriving from the various NSW asylums were symbols of order and psychiatric classification schemes in miniature: passengers were boarded according to criteria of sex, diagnosis and age. For example, in April 1947, Kenmore admitted a busload of 30 men from Parramatta who had been diagnosed with either schizophrenia or dementia; and in November 1948, 15 men with dementia arrived from Gladesville. In February 1948, 43 women arrived from Callan Park. The average age was 57.9, with 37% over 60 years of age.

Conditions in NSW asylums in the 1950s appeared to deteriorate even further. The following is an extract from the Inspector-General's Annual Report for 1956:

> Despite the extensive remodelling and rebuilding programmes that have been in force, the position in regard to the accommodation of patients is no better now than it was 10 years ago – in fact, it is worse.
> Ten years ago there were 1667 more patients in the Mental Hospitals than they were built to accommodate. Last year there were 2369. ...
> To place 2369 people in wards that originally made no provision for them must inevitably lead to serious over-crowding. From that over-crowding all manner of difficulties arise. The patients are crowded, the staff are hampered in their work, treatment suffers, the auxiliary services of the hospitals (laundry, etc.) are overtaxed and the general administration of the hospital is made more difficult. ...
> To fit these additional patients into the wards it has been necessary to make the following improvisations:-
> 1. To place beds in certain wards so close together that the Medical Officer or nurses cannot stand between them.
> 2. To use verandah space for sleeping accommodation.
> 3. To convert day rooms into dormitories and so deprive the patients of their lounge rooms.
> 4. To place beds on the floor in the passageways, etc., when there is no further room for a fixed bedstead. ...
> This overcrowding has led to a lack of classification and segregation of patients, so vital for effective treatment. Well-behaved patients are in the same wards as difficult and refractory ones, inebriate patients share wards with the mentally ill, and epileptics in many cases cannot be properly segregated. High grade and low grade mental defectives occupy the same ward. This lack of classification has a serious depressing effect on the mental condition of the less seriously affected patients. (McClemens 1961:46-47)

The Inspector-General's Annual Report details deficiencies in the NSW asylum system that had been pervasive for decades, of overcrowded, sub-standard accommodation, and inadequate segregation of certain types of patients, all of which affected their ability to provide proper care. By the 1960s, however, conditions had begun to improve, marking the transition between Herd Care and Therapeutic Community. The NSW *Mental Health Act* 1958 and, earlier in the decade, the introduction of anti-psychotic medications such as chlorpromazine, provided legal and psychiatric grounds for a more liberal care approach. These new technologies of care were substantiated by the outcomes of the Royal Commission into human rights abuses at Callan Park Mental Hospital in a decade heralding the rise of civil rights and anti-psychiatry movements, and at the same time placing the asylum solution under public, critical scrutiny.

Callan Park Inquiry

In 1960, Callan Park was Australia's largest asylum, with a resident population of 1,783 (Bromberger and Fife-Yeomans 1991:24). A newly appointed Medical Superintendent, Harry Bailey, was appalled by conditions in the asylum, of substandard accommodation, widespread custodial and disciplinary practices, and a lack of appropriate nursing care, and consequently he prepared a report for the

Public Service Board.[61] The Chairman of the Public Service Board and the Under Secretary of the Department of Public Health consulted with the Commissioner of Police, and a police investigation into Bailey's claims was commenced (McClemens 1961:62). This investigation did not, however, substantiate his claims. Bailey decided to hold a press conference and a number of articles outlining his allegations were published in Sydney's newspapers (Bromberger and Fife-Yeomans 1991:27). Public response to the media coverage forced the NSW Government to establish a Royal Commission, headed by Justice McClemens to 'inquire into ... certain allegations of neglect, as well as the truth or otherwise of the allegations contained in the report written by the Medical Superintendent of the Hospital, Dr H R Bailey, in March, 1960' (McClemens 1961:63).

While some of Bailey's allegations were not substantiated by McClemens' investigation, the final report represents an indictment of the asylum's accommodation conditions and the standard of care provided by some of the nursing staff. The recommendations of the Royal Commission into Callan Park had repercussions for all NSW asylums, and these included the injection of additional funds and resources for ward refurbishments, the expansion of rehabilitation and resocialisation programs for patients, and the development of new curricula for psychiatric nurses. In the short-term, the asylum environment was modified to reflect and reproduce the facilitative technologies of therapeutic community. In the long term, these changes heralded the beginning of the gradual process of deinstitutionalisation, of emptying the asylum.

The open door settings of Therapeutic Community

The Therapeutic Community care regime marks a period when liberal care practices in NSW were broadened in scope and introduced to a wider range of patients. In 1963, the Director of NSW State Psychiatric Services (SPS) announced the move from custodial to therapeutic care (SPS 1963:10). These policy changes affected asylums physically:

> Symbolic of this liberal approach has been the removal of the high walls and fences around all our metropolitan hospitals. The public is coming to see that mental illness is an illness and not a crime. (SPS 1963:7)

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[61] Paradoxically, in later years Bailey became the subject of another Royal Commission and was held responsible for a substantial number of human rights abuses against patients in the Chelmsford Private Hospital between 1963-1978.

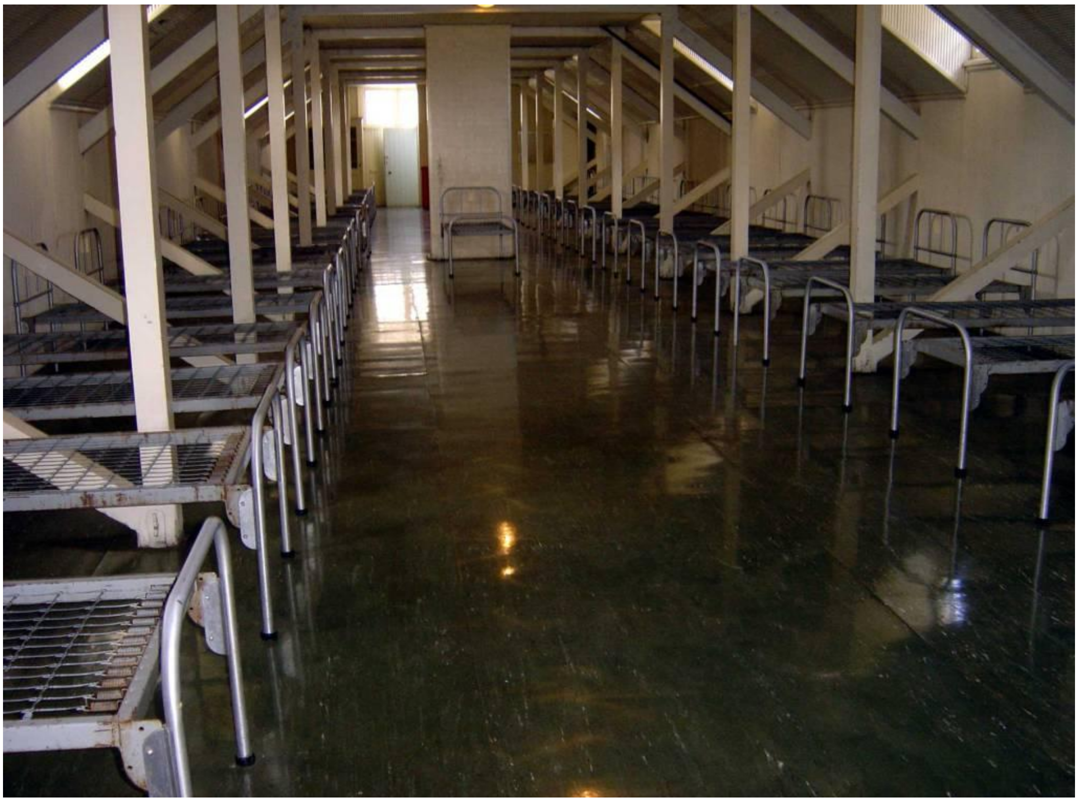

Plate 9: Domitory arrangement, Herd Care era, Kenmore Hospital 2005
Photo: D Kordes

Plate 10: Dormitory arrangement, Therapeutic Community era, Kenmore Hospital 2005
Photo: D Kordes

During the Therapeutic Community era, new patterns of asylum admission and discharge evolved. From the late 1950s onwards, in response to the new psychoactive medications and legal instruments, NSW admissions almost doubled while at the same time the long-term resident population began to decline. These trends were similar to asylum admission trends overseas, for example, in England, Wales and the United States (Scull 1984:67). The replacement of 'lunacy' with 'mental health' in the language of the NSW *Mental Health Act* 1958, and its greater emphasis on medical treatment rather than on confinement, may have contributed towards destigmatising asylum care, thereby encouraging people to seek psychiatric treatment at an earlier stage.

The *Mental Health Act* created new categories of residents. Formally recommended patients referred to temporary and continued treatment patients, inebriates, and 'those admitted for psychiatric examination' (SPS 1965-66:8). The new category of temporary patient was ordered to reside for a period up to six months, after which he or she was brought before a tribunal, where he or she could be discharged or reclassified as a continued treatment patient. In 1961, for the first time in NSW asylum history, voluntary admissions exceeded involuntary admissions. Of 5,967 admissions to NSW asylums, 3,307 were voluntary patients (SPS 1961:3). This represents a stark contrast to the 0.5-2.0% presence of voluntary patients during the period 1925-59. In 1961, Kenmore admitted 55 temporary patients (37M, 18F), 289 voluntary patients (159M, 130F) and 290 inebriates (245M, 45F). With reference to Kenmore, the increase in voluntary admission numbers was, among other factors, also attributed to the Therapeutic Community approach:

> The hospital is stated to be continually growing in status as a therapeutic community and the prejudices of days gone by are now rapidly being broken down. People are now far more willing to come to hospital for early treatment as Voluntary Patients than was the case in previous years, and this is reflected in the extremely small number of patients who have been required to be classified as Continued Treatment patients. (SPS 1961:11)

It seemed that more people were willing to consign themselves to the liberal care practices offered by NSW asylums.

The *Mental Health Act* made provisions for an easier and earlier exit from asylum care, and it was in the Therapeutic Community era that a 'revolving door' admissions scenario took off. In his Annual Report for 1962-63, the Director of State Psychiatric Services described this trend in terms of bed utilisation: 'for every 100 patients resident at the end of the year in 1954 we had admitted 53 patients during the year. In 1962-63, for every 100 patients resident at the end of the year, we had admitted 113 patients' (SPS 1963:4). Table 6.1 provides some insights into NSW admissions and residency trends at five year intervals during a 15 year period:

Table 6.1. Patient Admissions and Residency Figures NSW Asylums 1954-68

Year	Admissions	% per 1,000	Residents	% per 1,000
As at 30 June 1954	6,569	1.91	12,248	3.58
As at 30 June 1959	8,051	2.14	12,668	3.37
As at 30 June 1963	14,380	3.55	12,820	3.16
As at 30 June 1968	20,820	4.81	10,770	2.49

Asylum doctors believed that the new mental health laws and non-medical as well as medical treatments were key factors in admission and residency trends. In his 1963 report, the Director of State Psychiatric Services observed that the increase in admissions was 'due to a more comprehensive and adequate service being provided. The sharp upward trend from 1958-59 onwards must be partly due to the new mental health legislation introduced in 1958 bringing with it a greater acceptance of psychiatric treatment'. The 'efficiency' of NSW asylums, derived from a higher turnover of patients and a slow, unplanned reduction in resident numbers, was attributed to a combination of drugs and 'skilled professional staff to handle them and to provide a full range of treatment and rehabilitation programmes' (SPS 1963:5). Those reporting the increase in asylum admissions and the reduction in resident numbers described both trends as progressive. In 1968, Kenmore was reported in the Annual Report as follows:

> (p)rogress made at this hospital during the past year is demonstrated by the drop in hospital population.

In this year, Kenmore had experienced a drop in admissions from 1,345 to 913, and a drop in the daily average resident from 1,032 to 981 (SPS 1968:16). After the overcrowded conditions of the 1950s, it is not surprising that progress was measured in this way.

Progress was also equated with the fall of the inebriate presence in the asylum. Initially, inebriate admissions for NSW rose, from 217 in 1954, to 487 in 1959, to 1,009 in 1963. The rise in numbers was attributed to a rise in the incidence in alcoholism and to 'social and even administrative influences which are bringing a higher proportion of alcoholics under the psychiatric hospital control' (SPS 1963:7). By the mid 1960s, though, administrative changes brought about the decline of inebriate numbers, at least in Kenmore:

> in the latter half of the year, there has been a diminution in the number of patients admitted to this hospital under the Inebriate Act as a result of a new policy whereby many early alcoholics are now treated in metropolitan hospitals. (SPS 1964-66:31)

By 1970, the Director noted that for Kenmore:

> (t)he hospital has averaged approximately 80 inebriate patients, which is in marked contrast to the large number of inebriate patients previously accommodated. This reduction in the number of inebriates has been brought about by admitting many patients suffering from alcoholism, on a voluntary basis, and also because the metropolitan hospitals are assuming responsibility to treat the patients who suffer from alcoholism in their individual admission centres. (SPS 1970:39)

The change in policy, favouring voluntary admissions over the legal paperwork generated by the 1912 *Inebriates Act* may have been reflective of a wide-scale liberal approach towards persons under asylum care and treatment. The custodial emphasis of the *Inebriates Act* was out of step with the Therapeutic Community approach. Although the powers vested in the *Inebriates Act* have not to this day been repealed, psychiatry was able to use its discretion in how it would classify persons presenting with alcohol-related problems. The reclassification of the inebriate to the ambiguous, catch-all category of voluntary patient also avoided an embarrassment for the psychiatric profession, of the asylum typecast as a human warehousing facility for the alcoholic.

The drop in resident numbers encouraged the *better separating out* of patients. Wards were reclassified in ways which divided up and separated inmates as well as reintegrated them in novel ways. In the context of a declining asylum population, it became possible to divide the inebriates, retards, geriatrics and the psychiatrically dis-ordered, as well as segregate according to psychiatric diagnosis. For example:

> An attempt has been made to separate the inebriate patients from the newly admitted psychiatrically ill. ... Those who are physically ill go to the Admissions Centre Wards and those who have a potential for early rehabilitation are sent to Male 8 Ward and integrated into the Fairlight Hall Group Therapy Unit. (SPS 1964-66:31)

For a short period in the late 1960s, ward classifications also reflected residents' eligibility for the disability pension.[62]

The shift to a Therapeutic Community approach involved the modification of the asylum's physical and human geography. Reflecting the new training programs for nurses and programs for training inmates for freedom and responsibility in the community, the asylum's buildings and grounds were

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[62] The introduction of the pension is discussed in Chapter 12.

refurbished and new buildings were constructed. A former operating theatre at Kenmore was turned into a centre for group therapy and occupational therapy workshops were constructed, reflecting the rehabilitative focus of Therapeutic Community. Similarly, cottages – half-way homes - were constructed on the periphery of Kenmore, thereby physically marking residents' progress towards rehabilitation and recovery.

At the same time as Kenmore was implementing new dividing practices, there was a gradual reintegration of the genders commencing with supervised interactions between Male 3 and Female 3 Intermediate wards. In 1963, these wards became the loci for the implementation of therapeutic community techniques. In addition to providing the spatial settings for early experiments in male/female social interactions, these wards were also renovated with a view to giving each inmate more privacy.

Over time, wards were renumbered and renamed to reflect the changing human geography and by the 1980s, most wards had become integrated spaces, with male and female patients and staff living or working under the same roof. The new names such as, for example, 'Oasis', 'Lobelia, and 'Dinderra', were not meaningful names to the newly arrived or to visitors regarding the categories of patients the asylum catered for. The new names were rather an expression of the asylum's effort to disassociate itself from custodialism and to strive for the Therapeutic Community aims of normalisation and integration, to the degree that '(m)any members of the public have been surprised to discover the pleasant and normal atmosphere prevailing in our institutions …' (SPS 1963:7)

Lower resident numbers provided more opportunities for Therapeutic Community interventions. By 1970, NSW asylum resident numbers had declined from 12,539 in 1960 to 9,430. In his Annual Report for 1971, the Director of Psychiatric Services notes that the 'reduction in patient numbers has enabled substandard accommodation to be abandoned or renovated with a substantial reduction in standard bed numbers' (p.4). Standard ward patient numbers could now be reduced, from 60 to 40, providing space for 'individual clothing locker' and 'leisure and therapeutic activities' (p.4). In its overcrowded eras, these wards had accommodated up to and over 100 patients.

Asylums were no longer the overcrowded and substandard accommodation facilities of previous decades. Creating an aesthetically pleasing environment for their patients became part of nurses' daily routine:

> *When Dr C came, he really ... supported us in improving the physical ... décor of your wards and things, to make it more attractive. He would always say, "what are you doing now? What are you doing this week?" And I'd say, "Oh, I'm buggered, I'm having a break." "Oh no", he'd say, "you better keep going". I'd say "Yeah, but look, we've just got all those lovely photos and pictures around, and so and so has gone and smashed all the glass." "Oh", he'd say, "well give it another go". You'd do all these things to try and make their environment better for them, get nice pictures or rearrange the place different to make it look nice. Even get ... nice tablecloths ...* (Linda)[63]

By the 1970s, the Therapeutic Community approach had been introduced to all Australian asylums (Savy 2005:207).

The locked door spaces of Therapeutic Community

Wards reflected the amount of freedom, responsibility and choice available to their inhabitants. Custodial and disciplinary techniques of the *locked door* era had not been abandoned but continued to form part of the asylum's repertoire of treatment and care. The disciplinary mechanisms of the asylum were slowly relaxed for some but not for all. Destructive and violent patients, escapees, low-functioning retardation patients, the senile and the demented, and newly admitted patients still required a level of surveillance that involved maintaining restrictions on their freedom of movement. For alongside its objective of 'civil restitution' of the patient was the asylum's overarching and enduring responsibility to ensure the safety of staff and patients and to maintain its project of upholding the 'norms of order and conduct' (Gordon 1988:278).

Not all spaces of Kenmore's physical geography were exposed to environmental improvements. Ward conditions reflected staff assessments of residents' capacities to appreciate them. For example, wards for the *severely institutionalised* or the *violent* were unlikely to be renovated: the inmates of these wards were regarded as having no capacity to appreciate ward refurbishments, and it was believed that improvements to the environment would have little or no effect on their behaviour. Indeed, it was believed that these inmates would more than likely destroy any efforts at making their living surroundings more comfortable and aesthetically pleasing.

Alison recollected how the refractory ward *with the exception of its bathrooms was a ward that had very little renovations done to it.* The

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[63] Reminding us of the discrepancies within and overlaps across the care regimes, the Evacuation Officer reported to the Inspector-General on 29 May 1942 that: 'The practice of allowing patients to have their own private furniture had grown up at Kenmore, the whole of this furniture being of good quality and valuable.'

appreciation of an aesthetically pleasing environment was supposedly lacking in the refractory inmate. This category of resident was therefore regarded as potentially destructive of any improvements to the ward environment. The *wet end* of the male refractory ward, a series of seclusion rooms tiled from ceiling to floor, each room fitted with a run-off hole to enable staff to hose off faeces and urine from its walls, remained an environmental feature of Therapeutic Community.[64] At least until their condition had stabilised and they had become psychologically accessible, residents of the *wet end* were not exposed to the freedoms and responsibilities offered by this care regime.

Accordingly, the *open door* policy of Therapeutic Community was modified by nurses in correspondence with their understandings of patients' capacities for responsible and rational behaviour. Linda described how the ward spaces were kept safe and orderly for low-functioning retardation patients:

> *Linda: (V)ery few of them were ever allowed freedom of the, ah, sleeping areas, for many different reasons, some because of their destructive behaviour, others because of their feeding behaviour, or, and I mean you just couldn't have them all walking through the door ...*
> *Doris: What do you mean, freedom of the sleeping areas?*
> *Linda: Well, just able to go through to their bedroom any time of the day or night. Some of them of course, um, were still destructive, were physically destructive of the furniture and other people's belongings and things like that. ... It was the type of people we had. Other wards, you know, they could [go] ... everywhere, every area of the ward all the time.*

As well as the residents of low-functioning retardation wards, refractory patients were subjected to similar surveillance and control measures. While it was not unusual for a ward of male patients to invite the equivalent ward of female patients, and vice versa, to listen to music on the gramophone and have dances, *one never put the refractory wards together*.

The emergence of new communities across asylum boundaries

The declining resident patient numbers as annually reported by the Director of State Psychiatric Services indicate that an informal process of deinsitutionalisation, the prerequisite for Community Care, had commenced in the 1960s. This trend was generally supported by psychiatrists. In a conference on community mental health held in NSW in 1966, the Medical Superintendent of Gladesville Hospital noted that:

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[64] There was no equivalent to the *wet end* in the female refractory ward. This was explained by nurses in terms of the physiological differences between the male and female anatomies.

> Treatment of new patients in their own milieu has superior results to those gained when the patient is isolated from his community. ... Gaining re-admission to his community and attempting to re-establish himself in his former role, is often a task of such magnitude that failure to achieve this aim is almost guaranteed. ... Also, treatment in the community of new patients as far as possible would obviate the very definite stigma which becomes associated with this person ... (Frame 1966:18)

During the 1960s, the shift from asylum to community care solutions was increasingly regarded as a humane and enlightened answer to the problem of psychiatric dis-order:

> Now we are on the edge of a more fundamental change. Even in our lifetime we shall see psychiatry move into the community and a new attitude emerge to mental illness, its prevention and its treatment. Perhaps this is the most exciting phase of all, for with support, tolerance and group understanding we may together learn to carry more of the stresses of civilisation within our new community structure. (Dax 1961: 205)

At the same time as care in the community was described as a progressive move into the future, the asylum became increasingly associated with the past, as an anachronistic, stigmatised and stigmatising total institution productive of and contributing to inmates' psychopathologies (Barton 1959; Berks 2003; Goffman 1961).

The move to care in the community liberated the profession Psychiatry from the asylum as much as it did the patient. Not surprisingly, this liberation was also framed in terms of progress, of embracing the new stage of knowledge and practice for a 'modern' psychiatry. In 1963, the Director of State Psychiatric Services provided a rationale for the expansion and extension of the terrains for psychiatric practice:

> We must look more searchingly at the need for adequate community psychiatric services. Physical treatments are only partial treatments. Patients must be treated at the earliest possible moment even before admission is required and, once treatment is initiated, there must be frequent follow up interviews with provision of psychotherapy, occupational therapy, social rehabilitation, family therapy and review of treatment. ... modern psychiatric services place maximum emphasis on early treatment of patients as outpatients, in their own homes or in the outpatients departments close to their homes. As a second step, day hospitals provide more comprehensive supervised treatment in the community in which the patient lives. ... Psychiatric patients and their relatives are often poorly motivated to seek treatment ... psychiatric services cannot wait for people to seek them out. Services must be taken to the people. (SPS 1963:5-6)

NSW psychiatry provided additional justification in terms of the growing market demand for its services:

> The rapid growth in population of this State and the increasing demand for mental health services from all sections of the community make it essential that our activities extend well beyond the walls of the psychiatric hospital into the community which surrounds that hospital. (SPS 1964-66:5)

The extension of the psychiatric enterprise implies that the emerging regime of care in the community did not develop in the dispersed geography of the community but borrowed from existing knowledge developed in the asylum and techniques mobilised by asylum staff. The melting away of the boundaries between asylum and community provided a pathway for psychiatry to extend its influence 'into areas from which it remained excluded so long as its practice was confined along with its patients to impregnable institutions' (Castel *et al* 1982:172). Perhaps just as important to understanding the impetus for emptying the asylum, then, is the reconfiguration of the psychiatric profession itself:

> At the professional level, … what was at stake was not a desegregation of the mentally ill, but a desegregation of psychiatry, a desire of psychiatrists to end their isolation and gain access to the power, careers and status of other medical specialisations. (Rose 1988:55)

The psychiatric 'net' expanded at a steady pace, through the growth of diverse therapeutic interventions and service providers, and the establishment of psychiatric wards in general hospitals. As a consequence of the availability of new drugs and the growing presence of psychiatry in the community, a phenomenon in western states referred to by Rose as the 'psychiatrisation of everyday worries' commenced, with general practitioners in local communities at the forefront of the new prescribing patterns (Rose 1988:69).

The fragmentation and transfer of accommodation and vocational support services from the asylum to community commenced in the mid to late 1960s (SPS 1969 and 1970). Community services delivered programs based on Therapeutic Community techniques developed in and run by the asylum, such as Activities of Daily Living Skills and outpatient clinics (SPS 1970:40). Kenmore established the Church Street Hostel in Goulburn, providing accommodation in a supported environment and acting as a community drop-in centre during the day (SPS 1970:40). These trends occurred as part of a four stage plan by government and psychiatry for developing 'comprehensive mental health services', including the geographic regionalisation of responsibility for each mental hospital, the subdivision of each mental hospital into subregional units; the decentralisation of services into local communities; and the creation of inpatient psychiatric services at general hospitals (SPS 1967:5).

Emptying the asylum

In his final report as Director of State Psychiatric Services, Dr William Barclay noted the continuing decline in asylum residency numbers and associated this with the rise of community mental health services (SPS 1971:5). Barclay offered some advice to the new Health Commission, an organisational entity that was to incorporate the functions of the State Psychiatric Services:

> This may be the final report by any Director of State Psychiatric Services for New South Wales, as by the time the next report can be presented the position of Director will have made way for the Health Commission of New South Wales. It is to be hoped that the disappearance of this position with its specific responsibilities will not mean any lessening of the standards of care, protection, and treatment of the mentally ill. The mentally ill are a silent minority whose needs are easily overlooked as the history of our own mental hospitals has shown. It would be sad indeed if in our enthusiasm for the future we were to forget the lessons of the past. (SPS 1971:3)

Members of the Health Commission of New South Wales were appointed in 1973 and in the same year the first report was submitted. The office of the Director of NSW State Psychiatric Services had been abolished by the legislation that established the Commission and 'absorbed within the structure of the Bureau of Personal Health Services' (NSW Health Commission 1973:6). The Bureau was allocated responsibility for Aboriginal health, alcohol and drug dependency, community health, geriatric and rehabilitation services, the mentally handicapped, maternal and child health, nursing, social work, and psychiatric hospitals. On page 5 of the 1973 report, it is noted that '(r)eturning to the matter of annual reports, the Commission has inherited a system of reporting which should be preserved to some degree, at least at this stage.' In the following year, reports of individual psychiatric hospitals were listed under the region they serviced, for example, Kenmore Hospital appeared under 'South Eastern Region'. Asylum reports were now limited to approximately 150 words, a stark contrast to the detailed correspondence submitted by the various incarnations of Inspector-General of Mental Hospitals and more recently, Director of NSW State Psychiatric Services.

The Richmond Report

The dismantling of NSW asylums that commenced during the Therapeutic Community regime continued into the 1970s. It accelerated after the recommendations of the *Richmond Report* (1983) which provided a blueprint for the decentralisation and outsourcing of the asylum onto non-government organisations and psychiatric units of general hospitals. The Report recommended a program for the rationalisation and reduction of asylums (pp. 5-11).

Unlike the cheerful and optimistic writings of Annual Reports submitted by the Director of Psychiatric Services in the Therapeutic Community era, the *Richmond Report* described asylums as isolated institutions segregated from the community, and fostering client dependence. The stigmatisation of asylums by policy makers and health professionals justified the Report's recommendations.

The expenses of running asylums and their role in marginalising patients from the community were other reasons put forward to justify their rationalisation. Asylums, the Report notes,

> absorb most of the resources for the services being examined. In the Inquiry's view the perpetuation of a segregated system ... of service delivery dealing largely with a population of socially and economically disadvantaged clients denies these clients the possibility of access to better treatment and assists in maintaining their disadvantage. (p. 28).

It was estimated that the 'potential level of savings' from the rationalisation of asylums would be 'low conservative figure of a 10% saving' to current operating costs (p. 44).

While the Report recognised that Community Care would increase people's risk of becoming homeless, impoverished, vulnerable to forms of discrimination and violence, and more likely to spend time in police lockups and the prison system, this was regarded as preferable to client dependence on government services. This view was framed by asserting that risk was an inevitable aspect of life and should therefore not be controlled for too vigorously:

> Vulnerable people will always be "at risk" in society … The fact that people are "at risk" should not be used as an argument to perpetuate inappropriate custodial care. Those people who suffer from serious mental illness often require supportive accommodation and occupational activities, but they do not necessarily require hospital treatment or custodial care. (1983:16)

In 1962, there were few than 13,000 residents in NSW asylums. By 1973, resident numbers had dropped to 8,761 (Fry 1987:48). In 1981, the Health Commission (established in 1973) reported that NSW 'hospitals for the mentally ill, developmentally disabled and persons admitted by a court order under the *Inebriates Act* 1912' had a total of 4,341 residents as at 30 June 1980, 596 of whom resided in Kenmore (Health Commission 1981:77).

Nurses' recollections of the emptying of Kenmore were reminiscent of a technical procedure for moving bodies rather than a process for emancipating patients. The arts of administration were dictated by the need to dissolve an ideologically obsolete form of mental health governance that was privileged over considerations of individual choice. Decisions about community placements for patients were oblivious to context. Administrators were not looking for complexity and difference but were instead focused on finding expedient solutions. Nurses' memories of the bureaucratic priorities given to the emptying of the asylum are evocative of an earlier period in Kenmore's history, of the large-scale evacuation of all inmates during the take-over by the Australian Army in 1942 and their subsequent repopulation in 1946.

In the course of depopulation, patients were assessed for their capacity to live in the community:

> *Brenda: Did anyone mention about the assessments that we had to do? Well, they brought in these assessments ... and this was to see who was ah, to go out into the community, that was when they were emptying the place out, slowly. ... Now a lot of the questions on these assessments just didn't apply to patients and some of them, I'll give you an example, Miss M, she could, she had done her own shopping, she had her own furniture, she had her own cooking stuff, everything she owned when she came in here she brought with her. And did her own cooking and everything. Her own washing. And, she'd done everything for herself. Right? Now, on those assessment forms, she'd have been an ideal patient to go out, but because she was so paranoid and wouldn't eat hospital food because* [she believed] *everyone's trying to poison her, no way could she cope in the community.*
> *Linda: She had all these, these real paranoid sort of ideas. I mean, she'd been in for 60 years. ... she'd been a really crazy sort of a woman.*
> *Brenda: But when she was living here she could do for herself. But to put her out in the community was ridiculous, it was ridiculous. And when she left here to go into the community she would have gone to one of these ah I'd say nursing homes, because of her age. And she wouldn't have lasted because she wouldn't have eaten food, they wouldn't have understood ...*
> *Doris: So the assessments didn't take, didn't ask those sorts of questions?*
> *Brenda: They didn't, no. Well see, the questions were there, and we could answer 'em, but they never, no one ever came to talk to us about um, do they look alright on paper and on the computer. But no one ever said, um, what's your opinion, do you think she'd cope in a nursing home. Because she wouldn't have. And then there was* [another patient] *who could wash herself and dress herself. She was like that elderly old retard. She swept the wards up, she pottered all day*
> *Linda: And she could say some things but a lot of things she couldn't.*
> *Brenda: ... a lot of things she mumbled. But we could understand her. ... You got used to the way they talked ... Now that poor old ... she'd been here for about 60 years, and they bundled her up and sent her to Sydney, and she liked to wander around the grounds here, didn't she, and she'd have been ...*
> *Linda: Well she died not long after, we heard.*
> *Brenda: Yeah. ...*
> *Linda:* [talked of the grounded knowledge about patients that staff gained over the *long, um, where they never had to, they never had any stress, any of the stresses of life.* years] *... but not only that, they were also institutionalised. They had been*

> *here so They never had to think about anything, you know, their meals, where their meals were coming, where the money was coming from or what money was or ...*
> *Brenda: ... to go out into the community and they'd been picked on a computer without any, um ...*
> *Linda: Oh, we had so many arguments, fights, damn near tears,* [with psychologists and psychiatrists over this process] *... we battled on, and we kept some of them didn't we, for a few years, but in the end we lost the battle.*
> *Brenda: Because they always thought we were overprotective and possessive.*
> *Linda: Yeah.*
> *Brenda: And we weren't, really, because people who could go into the community and some of them have done really well, haven't they? ...* [but] *some of the real old ones that had been here for 50-60 years, this was their home and their village and it was, wasn't it?*

The residents of Kenmore were not given a choice about where they wanted to go or the choice of staying. This was not unique to Kenmore or NSW but reflective of an historically widespread, governmental imperative of developing managerial solutions for a problematic population group.[65] For some, 'community' translated into little more than a transfer into another kind of institution such as the nursing home. Szasz describes this phenomenon as transinstitutionalisation, where former patients are 'rehoused in para-psychiatric facilities, such as group homes and nursing homes' (Szasz 2005:78). These 'new asylums' also include shelters and prisons (Bostock and Gleeson 2004:49; Coleborne and Mackinnon 2006:376; Richmond and Savy 2005:217).

In group discussions and interviews with nurses, a theme emerged, of the devastating effect on the frail and the aged of moving to an unfamiliar environment. For the long-term elderly resident, far from being a locus of healing and recovery, the community solution may have represented a death sentence:

> *Joanne[66]: The saddest thing I think I saw here was when they actually wanted to renovate Ward 19. ... And mind you, it needed renovating. But when they needed to move all the people out of there, they moved them into nursing homes. Now, we had our community nurses go and visit these people placed temporarily in nursing homes, and they died. They died within days. They died before the place was finished to come back. Even though we'd told them that they'd be coming back, they just died. ... And that was the thing that worried me the most about this community move for our older, er, disabled people was – that they'd die ...*
> *Doris: So, how long were they in this nursing home?*
> *Joanne: Not long.*
> *Doris: What, maybe six weeks?*

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[65] Similarly, in the 1990s, during the dismantling of 'Hilltop', an institution for the intellectually disabled, Johnson observed that: '(i)n the interplay of discourses which freed the women from the locked unit, they remained strangely silent and removed. The discourses moved around them. Information was gathered about them. Their lives were talked about by those exercising power over them. Their "subjectivity" was dissected, measured and assessed according to prearranged schedules and check-lists. … Their fates were determined by the judgements of others.' (Johnson 1999:165)

[66] Joanne commenced working in Kenmore in the 1970s.

> *Joanne: Yes. It's almost as if they've said well, they've taken my home, my life is stuffed, I'm booking off.*
> *Doris: And how many patients were moved into a nursing home?*
> *Joanne:* [speculation – approximately 20-30 patients would have been moved]
> *Doris: When did this happen, this renovation?*
> *Joanne: It was in the 1970s …*
> *Doris: How many died?*
> *Joanne: There would have been a few of them. Because every time our … domiciliary nurses would go and visit, there'd be another one dead. …*
> *Doris: That's an amazing story, isn't it, because living in a place –*
> *Joanne: For years and years and years, and all of a sudden, just – gone …*
> *Doris: What kind of care was that, huh?*
> *Joanne: Yeah, but I think it was, you know how they say when someone is sick of living or they just decide to die they do? … We've even had people say to us, who've had to go to surgery, and they've said, 'am I coming back'?*
> *Doris: OK, so moving patients from a long-term home environment – bad for their health?*
> *Joanne: Terminal. … You might as well take a gun to these people now if you're going to move them, because they're going to be dead in no time. … but there are people who could cope with it* [Community Care] *and are still coping with it, and for these people it's great.*

Nurses' recollections of the repercussions of emptying the asylum and the transinstitutionalisation of older asylum residents are consistent with a body of literature that provides evidence of 'a close correlation between the relocations of chronic patients and sharp increases in their mortality rates' (Scull 1983:345).

While nurses and other allied health professionals continued to be engaged in the arts of Therapeutic Community in the asylum, a process of demarcation slowly evolved, between the asylum as locus of practices associated with medical/clinical interventions, and non-government organisations as loci for practices associated with rehabilitative care. Recognition of this governmental trend was encouraged in the Richmond Report. In addition to placing political and fiscal pressures on asylums to increase their rate of deinstitutionalisation, the Richmond Report recommended the organisational separation of the developmentally disabled from the psychiatrically dis-ordered.

In 1985, Kenmore was segregated into two autonomous administrative bodies now referred to as Kenmore Hospital (providing services for 'psychiatric disability') and Strathallen (providing services for 'developmental disability'). The *split* included moving funding and administrative responsibility for the developmentally disabled from the Department of Health to the Department of Community Services. The asylum's buildings and grounds were thus converted into two separate institutions. The *split* was enforced as rigidly as in an earlier period in Kenmore's history of gender segregation. It not only divided up the physical landscape; social ties between patients were effectively ended.

Under the recommendations of the Richmond Report, patient numbers for the psychiatrically dis-ordered were to decrease in accordance with budgeted target figures. Buildings were gradually emptied. It was not unusual to see inmates trying to access empty buildings, *to visit someone they knew who lived there* (Jane). The buildings and grounds of the Kenmore *campus,* as it was now referred to, were gradually allowed to deteriorate and become run down. By the 1990s, the asylum's services were decentralised and regionalised. Authority for Kenmore had been removed from the Medical Superintendent, a position which was abolished in the early 1990s, and decisions about the small number of remaining patients were now made from outside the perimeters of the asylum.[67]

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This chapter described how twentieth-century priorities of government and psychiatry were negotiated and realised in the shifting social and political landscapes of the asylum. I considered the different ways in which the form and function of Kenmore's buildings and grounds were realised in practice. Throughout Kenmore's history, the asylum's dual roles of custodial institution and therapeutic milieu continued as constants of organisational life. While these roles were differently emphasised in the care regimes of Herd Care and Therapeutic Community, they each remained integral to deciphering the meanings inscribed in the asylum's moral architecture.

While many of Kenmore's buildings stand abandoned and decayed, the roles they once played live on in the new geographies of mental health governance. Asylum practices of classification, segregation and exclusion continue, as do their repressive and rehabilitative intents, in the physical and human landscapes of Community Care. In the next chapter I examine how the arts of care, have been divided and separated out in fragmented, diverse governmental settings that have been typified in the literature as a 'squirming and changing psychedelic labyrinth', and that we refer to as 'community' (Gudorf, in Angrosino 1998:29).

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[67] At the time of research, Kenmore accommodated approximately 50 patients.

7. Mapping the Spaces for Community

> It is dangerous to assume that a community is homogeneous, or indeed that the ‘community’ will form part of the therapeutic process for a patient (Holden *et al* 2001:522)

This chapter provides an historical overview of the design and growth of Canberra’s psychiatric services and maps aspects of its heterogeneous social and physical landscapes. That is, in addition to a chronologically ordered discussion of the policy discourses underpinning care in the community, including their premises of integration, acceptance and therapeutic treatment, I describe some of the forms and functions of the spatial settings for Community Care. Field notes taken as a participant observer, including data obtained during formal 47 interviews with consumers, carers and community sector workers, describe the tangible spaces for care and provide insights into the different meanings attributed to ‘community’. The notes reveal how, in the process of emptying asylums, the arts of care fragmented and diversified into a plethora of settings for confinement and recovery; medical and non-medical treatment. The theme of a fragmented community emerges.

Need is a term that is suited to the contingent, fragmented community, and Canberra’s mental health geography was designed to be reflective of the diverse *needs* of persons diagnosed with a psychiatric condition. The concept of *need* is malleable and can address social location as well as multiple diagnostic categories. We have different *needs*, including *complex needs* and *special needs*. Over time, our *needs* change. Care for the Canberra community was designed to be ‘flexible’ and ‘diverse’ in order to be able to respond to a range of different *needs* (Cramond 1967). Accordingly I suggest that, only by apprehending the ways in which the fluctuating *needs* and capacities of mental health consumers interconnect with diverse arts of care does the logic and coherence of a fragmented ‘community’ become visible.

The emerging vision of psychiatric services for the Canberra community

Deinstitutionalisation may be described as a process whereby the arts of care that evolved in the closed community of the asylum were gradually divided up and outsourced into dispersed and diverse physical locales of the wider community, in out-patient clinics, day and in-patient hospitals, community mental health centres, supported accommodation facilities, respite care houses, recreational activity programs, and occupational and psychosocial rehabilitation centres. The policy discourse of care in the community was generated by human rights concepts of access and equity. It was underpinned by the belief that it was feasible to *blur* the social boundaries between the psychiatrically dis-ordered and the community (Shea 1965:27; Pinfold 2000:202). It was believed that the blurring of these boundaries would not only facilitate recovery but would also remove the stigma associated with psychiatric dis-order. Psychological healing was no longer confined to the psychiatric ghetto of the asylum. In contrast with the asylum's traditional culture of segregation, dependency and paternalism, community programs and activities would promote the normalisation of the mental health consumer (Pinfold 2000:206). Not surprisingly, the shift to community was presented in terms of progress:

> Perhaps this is the most exciting phase of all, for with support, tolerance and group understanding we may together learn to carry more of the stresses of civilisation within our new community structure (Dax 1961:205).

As a young town unblemished by the stigma of the asylum landscape, Canberra embraced the new governmental arrangements for care of the psychiatrically dis-ordered. To reinforce the discourse of progress in the management of the mad, the role of the asylum was diametrically opposed to a community model of care:

> Two or three decades ago the chronic mentally ill patient often entered hospital early in his adult life, and there he stayed, passing through a sequence of remissions and relapses with little prospect of release. When hope had withered, and nothing was left to strive for he assumed the armour of morbid indifference, he became institutionalised and this condemned him to remain. ... (t)here is now an emphasis on therapeutic and social support for the patient in the community and mental health workers are beginning to concern themselves with genetic, family, social, and environmental factors in the cause and control of mental disorders. Thus mental health care is no longer a purely medical prerogative, but a co-operative responsibility of medical, psychological, social and lay workers. (Mickleburgh 1980:3-4)

This progress narrative, written by a psychiatrist and former director of mental health services in the ACT, envisaged the expansion of psychiatric practice in the wider, geographical treatment net of the community. It was believed that the rationalisation of asylums, as proposed by the Richmond Report three years later, would lead to improvements in service provision, increase opportunities for community integration, and result in the reduction of stigma associated with psychiatric dis-order.

In the planning of Canberra's community services a moral environment was articulated by its designers that would offer consumers the choice and flexibility to access services based on individual *needs* while living in freedom in the community. Whereas classification schemes of the asylum had ordered inmates' movements through wards based on their assessed capacity for autonomy, self-governing consumers would be encouraged to take responsibility for navigating the terrains of community based on their fluctuating *needs*. The function of 'community' was thus based on a conceptualisation of the psychiatrically dis-ordered as self-managing and self-responsible agents.

In 1962, Australia's leading psychiatrist and architect of service provision, Eric Cunningham Dax, was commissioned to write a paper setting out a vision for the development of psychiatric services in the ACT. In his report, Dax recommended that Canberra's psychiatric services be established over three stages in accordance with the *needs* of a young, fast growing population. While some of the recommendations of Dax and other clinicians subsequently engaged in the planning of Canberra's psychiatric services, including Cramond (1967), Hennessy (1969 and 1972) and Mickleburgh and Porritt (1976), were ultimately not adopted, in particular those recommendations that involved substantial investments into hospital-based resources, they were still influential in shaping Canberra's mental health community through their promotion of the key principles of care in the community, of decentralisation and regionalisation.

In this design and development phase, aspects of Canberra's demography were taken into consideration. In 1967, in the report *An Appreciation of the Psychiatric Services of the Australian Capital Territory with Recommendations for Future Development*, Cramond noted that Canberra's population of 100,000 was overrepresented by a:

> large migrant "floating" population, large numbers of junior Public Servants heavily in debt "to keep up with the Jones", and a high proportion of young mothers deprived of extended family support on moving to Canberra. (Cramond 1967:3)

A psychiatric profile of Canberra suggested that there was 'much heavy social drinking' and 'approximately 300 cases of attempted suicide annually' (Cramond 1967:2). Two years' later, in his *Plan for Psychiatric Services for the Australian Capital Territory*, Hennessy referred to a 'suspicion' amongst clinicians 'that the rates of mild and moderate disorder may be higher, while the rates of severe disorder may be lower than in other parts of Australia' (Hennessy 1969:4). By the

1970s, the psychiatric *needs* of Canberra residents were believed to have changed as the population aged, and the number of acutely or chronically ill people seeking psychiatric treatment increased (Hughson 1986:1-2).

In 1976, Mickleburgh and Porritt described Canberra as a young population with 'a substantial minority of migrants, high incomes and high education' (Mickleburgh and Porritt 1976:1). The socioeconomic status of Canberra residents may have had a bearing on their preferred pathways for seeking psychiatric care and treatment. It was noted that 'senior people' were more likely to go interstate, visit their family doctors, the clergy or voluntary groups than to seek treatment from a public psychiatric ward (Cramond 1967:2). Hennessy observed that '(i)n a rapid survey of eight Sydney-based private psychiatrists, it was found that 30 patients from the ACT had attended them in the past 12 months' (Hennessy 1969:3). It seemed that 'Canberra residents view Kenmore as the end of the line': admissions to NSW asylums from Canberra were 124 in 1966-67 representing 123 per 100,000 per population, in comparison with 402 per 100,000 for the NSW population (Hennessy 1969:3-4).

In recognition of the higher socioeconomic status of Canberra's senior bureaucrats and their families and the ways in which this impacted on their pathways for seeking care and treatment, Dax suggested that the *needs* of the well-heeled be taken into consideration in the design of psychiatric services. Aware that 'fears had been expressed regarding people with psychiatric illnesses from various economic levels having to mix with one another', he proposed that 'seriously disturbed private patients should continue to be treated in Sydney' and that after the opening of a second mental health unit in Woden, the Canberra Community Hospital should ideally focus on mainly private patients and the Woden unit on 'intermediate patients' (Dax 1962:15).

The planners of Canberra's future community services were cognisant of the role of architecture in influencing care and treatment, and believed it was a fortunate thing that the bricks and mortar of an asylum had not tainted Canberra's middle-class landscapes. Psychiatry formally acknowledged Kenmore's 'fine record for its work for the severely mentally ill' and its 'peaceful setting in beautiful surroundings' (Hennessy 1969:38). At the same time, the planners believed that the community represented a more progressive and enlightened approach to the care and treatment of psychiatric dis-order. In the absence of the requisite statutory authority, Kenmore was justified as an unpopular but necessary device for providing treatment and care for '*a few* patients with *special needs*' (Hennessy 1972:38, emphases added). Not having to contend with an asylum 'building based on outmoded concepts' gave the architects of ACT services a blank slate for designing services based on the principles of decentralisation and regionalisation, creative of 'small local units of varying types to meet *specialised needs* near to the patient's home' (Cramond 1967:3, emphasis added).

While Kenmore continued to provide care and treatment for the Territory's most recalcitrant and unruly patients, averaging between 110-120 admissions annually in the 1960s and 1970s, the asylum remained out of sight, 100 kilometres from Canberra's CBD (Cramond 1967:1; Hennessy 1969:38). Because its most difficult patients were shipped outside the ACT's borders to Kenmore and other asylums, the psychiatric planners did not have to design facilities for clients under involuntary care and treatment orders. Instead, the facilitative techniques of a therapeutic community approach were written into the report prepared by Dax. In that report he recommended that the first psychiatric ward, opened in the late 1960s in Canberra Community Hospital, be run on liberal care, therapeutic community principles, offering a range of services and activities such as 'physiotherapy and occupational therapy, a cafeteria, discussion groups, cinema, alcoholics anonymous meetings, social club activities' (Dax 1962:12). Hennessy envisaged that a second psychiatric ward, planned to open in Woden Valley Hospital in 1974, be similarly run along the lines of a 'permissive and therapeutic atmosphere' (Hennessy 1972:38).

The shift to community brought into relief some of the differences between the norms of care in the therapeutic community of the asylum and those of the general hospital. The Director of NSW State Psychiatric Services described these differences at a conference as follows:

> The general hospital is not accustomed to the permissive atmosphere of modern psychiatric care and finds it difficult to adapt itself to patients who do not confine themselves to bed during the day and who require a much greater area for occupation, recreation, and general social activities ... The general hospital administration cannot be expected to take kindly to the patient who comes home drunk after a day out on leave, or to the patient who threatens to jump from a fourth floor balcony. ... I do not know of many Sisters in charge of general hospital wards or of matrons in charge of Departments who would be happy to see a nurse sitting down smoking a cigarette and having a cup of coffee, talking with a patient, and yet it may well be that this nurse is doing, during this period of interaction with the patient, her most valuable and constructive work as a psychiatric nurse during her tour of duty. (Barclay 1966:43-44)

Implicit in Barclay's writing is his understanding of the role of rehabilitation, in particular, the 'permissive' arts of care that were introduced into NSW asylums in the early 1960s, as integral components of the pathway to recovery. In his description of the psychiatric ward planned for Woden Valley Hospital, Hennessy similarly observed that a 'reasonable degree of permissiveness in the acceptance of unusual behaviour and emotional expression is essential' and that the ward 'must be allowed to develop in its own style' (Hennessy 1972:35). The ward was subsequently named Ward 12B. A former Kenmore nurse who worked in 12B in the 1970s, Joanne commented on aspects of the permissive' atmosphere of the ward, which had *much more freedom, open spaces. But they only had voluntary patients. ... the clients over there had a lot more say in what went on.* Joanne did not enjoy her time in Ward 12, which she described as *babysitting stuff:*

> *They were mainly there because they were politicians' wives, and their hubby had been away and they couldn't cope ... Which pissed me off because it really wasn't true psych stuff ... it was an abuse of the system.*

Barclay's understanding of the differences between the different functions of psychiatric care and treatment was implicit in Dax's recommendation that separate positions of directors of psychiatry and rehabilitation be established. The Director of Psychiatry would oversee the 'mental health unit', while the Director of Rehabilitation would manage a 'psychiatric rehabilitation hospital' of 150-200 beds, on grounds of up to 50 acres. Dax had proposed that the rehabilitation hospital cater for:

> considerable outdoor occupation and for such other services as were needed to be added, for instance, for alcoholics, psychopaths or others if needed at a later stage. Vegetable gardening is a more satisfactory occupation than farming for patients (Dax 1962:9).

Although Dax distinguished between the work of clinical medicine and rehabilitation, his writings suggest that this demarcation was closely connected to ideas of how to manage certain categories of the psychiatrically dis-ordered in the post-asylum mental health landscape. In his discussion of the development of the Mental Hygiene Service in Victoria, for example, Dax noted that 'patients of very poor prognosis' were unsuitable for the 'open unit' of a psychiatric ward in a general hospital and should be sent to a long-stay facility, that is, the 'rehabilitation hospital' (Dax 1961:168). The rehabilitation hospital for Canberra was never realised, at least not on the scale proposed by Dax, most likely because it too closely resembled the stigmatised geography of an asylum and would have been costly to build and maintain.[68] Instead, a half-way hostel was constructed in the 1970s.

Watson Hostel was a 'half-way house' for patients discharged from Kenmore and who were 'not deemed ready to cope with stresses of the community' (Capital Territory Health Commission, cited in Potas 1982:108). It provided respite care and also promoted its services as 'a home (sanctuary or asylum) for the psychiatric patient who has a chronic condition requiring continuous supervision and who has no outside support system' (Potas 1982:108). Watson Hostel ran programs in 'self care, work, leisure habits and community involvement' (Potas 1982:109). It originally operated with 20 beds, but by 1984 Watson Hostel had the capacity to accommodate up to 40 patients.[69]

Community mental health services formally commenced operations in 1969 (Hughson 1986:1). Dax's report had affirmed the important role psychiatrists should play in coordinating the efforts of treatment, care and rehabilitation in the community. He recommended that psychiatrists 'take an active part in community care and maintain a close relationship with the relatives and the general public' (Dax 1961:168). Similarly, Hennessy emphasised the importance of psychiatry coordinating 'with all other helping services … to tackle problems and to improve the quality of life in the region' (Hennessy 1969:6). During the 1960s, 'dedicated lay bodies' were invited to take on responsibilities for rehabilitation (Cramond 1967:20). It was envisaged that the decentralisation and regionalisation of Canberra's psychiatric services in community health centres would foster closer working relationships with schools and other health and welfare services, thereby expanding and extending the possibilities for early intervention as well as rehabilitation (Hennessy 1972). These plans involved the employment of new workers, overseen by the psychiatrist whose role was to 'teach his insights and skills to others in the community' (Cramond 1967:20).

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[68] Twenty-one years later, a Working Party of the Capital Territory Health Commission examined future options for the ACT accommodation of chronic Canberra patients currently residing in NSW institutions. A discussion paper prepared by the Working Party noted that 'there has been a significant trend to move away from monolithic institutions … and for patients to be accommodated in smaller facilities. Equally obviously, bearing in mind the characteristics of the 28 persons, accommodating them in houses in the community would be unsuitable as well' (Mickleburgh, Griyell and Lambert 1983:4). The authors recommended that six 6-bedroom houses be built, each house enclosed by its own fence, and the 'village' of houses further enclosed by another fence (Mickleburgh *et al* 1983:6). Not surprisingly, this recommendation was not supported, most likely for the same reason that Dax's rehabilitation hospital was never approved.

[69] Watson Hostel was closed in the late 1990s.

To symbolise a more inclusive psychiatry, it was recommended that Canberra’s Psychiatric Services Branch be renamed the Mental Health Branch in 1972 (Hennessy 1972). The name change formed part of the recommendations of the *Stage II Plan of Mental Health Services for the Australian Capital Territory* (Hennessy 1972). It was suggested that the name shift reflected ‘a more positive approach, and the need for full participation by the community and by many different professions’ (Hennessy 1972:2). By 1976, the importance of community participation was formally inscribed into the recommendations of the *Stage 3 Plan for Mental Health Services in the Australian Capital Territory* that proposed the development of mechanisms for consumer feedback, the expansion of the role of volunteers, and the representation of agencies and community members on committees (Mickleburgh and Porritt 1976).

Ten years later, the paper *Policies for Mental Health Services, Draft for Discussion* prepared by the ACT Health Authority in response to recommendations of the Richmond Report, articulated the governmental arrangements for Community Care by formally endorsing new agents of government located in the community, and by reaffirming the model of decentralised mental health service provision:

> The responsibility for health care should be shared between the individual, the community, the professionals and the government.
>
> Government has an important role to play in identifying gaps in services and in ensuring the provision of services, but need not always act in the role of direct provider.
>
> The planning and provision of mental health services should involve consultation with all relevant government departments, the non-government sector, the private sector, community interest groups and consumers.
>
> The government should have a formal negotiated relationship with the not-for-profit, non-government sector regarding policies and resources to support their role in service delivery. (1986:2-3)

In the wake of the publication of this policy paper, a growing number of support groups and non-government agencies were established to fulfil their role in service delivery. The model of care articulated by the paper remains relevant for understanding the twenty-first century governance arrangements of Community Care.

The limits of care in the community

During the 1960s and 1970s, Canberra’s hospitals changed their names, and wards changed their functions; and with the construction of Calvary Hospital in the late

1970s, the psychiatric services of Royal Canberra Hospital (formerly known as the Canberra Community Hospital) were relocated to the newly opened hospital. After Canberra had achieved self-government in 1989, locked door technologies were introduced into the psychiatric ward of The Canberra Hospital (formerly known as Woden Valley Hospital). The ward was redesigned in the early 1990s to accommodate involuntary ‘patients’ after ACT legislation was enacted to compulsorily detain and treat them.

In 1969, Hennessy described the inability of Canberra’s psychiatric services to cope with demand, stating that ‘only 13% of attempted suicides treated at the Hospital are seen by Psychiatrists or Social Workers’ (Hennessy 1972:iii). By the 1970s, it was acknowledged that demand was exceeding capacity, and this was attributed to the ACT population growth of 9% per annum (Hennessy 1972:2). By 1976, the growth rate had dropped slightly to 6-7% (Mickleburgh and Porritt 1976). Psychiatry continued to advocate for the need to increase service provision and staffing levels.

Up until 1978, Canberra had 46 acute inpatient beds (20 at Royal Canberra Hospital, and 26 at Woden Valley Hospital). It also had the use of 12 full-time equivalent beds at Kenmore. In addition, residential care for the chronically unwell was available at Watson Hostel (20 beds), 25 beds at Kenmore and a small number of beds at other NSW institutions (Mickleburgh and Monahan 1979:3). In 1979, the beds at Royal Canberra were relocated to Calvary, and in 1984 Calvary opened a day hospital (Hughson 1984:1).

In 1979, a study into Canberra’s psychiatric services was undertaken to examine, amongst other things, ‘the developing overload situation in Woden Valley Hospital’s inpatient service’ (Mickleburgh 1980:1). The report noted that 30% of ‘patients admitted with a psychiatric diagnosis were being cared for and treated in medical wards’ (Mickleburgh 1980:5). Mickleburgh expressed concern for how the psychiatric wards would be able to manage if patients cared for in medical wards and by Kenmore Hospital had to be managed by existing psychiatric services, which he believed were inadequately resourced:

> psychiatric bed occupancy exceeds 85%, a considerable portion of psychiatric patients occupy general medical beds, and when the Mental Health Ordinance is enacted at least 10-12 extra beds will be required for the acutely disturbed patients who are at present transferred to Kenmore Hospital’ (Mickleburgh 1980:7).

Mickleburgh also noted that while medical wards might seem appropriate for suicide attempt patients, these patients also needed follow-up support in the form of ‘a more active environment and a fully structured programme of therapeutic activities’ (Mickleburgh 1980:7).

In an earlier paper on the residential care needs of Canberra residents, Mickleburgh and Monaghan had recommended that 34 beds be available in Calvary in 1980/81; 20 beds for child and adolescent psychiatry at Royal Canberra Hospital by 1990; 20 more beds for Watson Hostel (totalling 40); an additional ‘chronic facility’ of ten beds be established by 1980/81; and by 1982/83 a new psychiatric ward be opened. The authors predicted that the ACT would need 127 acute care beds by 1989/90 (Mickleburgh and Monaghan 1979:8-10).

Psychiatry was aware of the service needs of the Canberra population, and the papers prepared by well-known local figures such as Mickleburgh and Hennessy provided persuasive arguments for extending services. Some of their suggestions, however, were not in line with policy and fiscal priorities. For example, they consistently argued for more inpatient beds. In the wake of the Richmond Report recommendations in 1983 and the parallel rise of market place, liberal political rationalities that have impacted on public hospital funding levels, their wish lists were out of step with government. In Canberra, the availability of beds *per capita* have been in decline since the 1970s while at the same time the nation’s capital has continued to grow, from 144,000 in 1971 to 333,940 in 2006 (Bruen and Hennessy 1975:223; Australian Bureau of Statistics 2008).[70]

In 1986, in a bid to manage admission numbers more effectively, it was recommended that Canberra’s psychiatric wards admit only those patients whose *needs* met their selection criteria. The paper *Policies for Mental Health Services, Draft for Discussion* recommended that ‘highest priority should be the community-based care and rehabilitation of the seriously mentally ill’ (ACT Health Authority 1986:6). The rationale for this policy shift was explained by the Director of ACT Mental Health Services as the consequence of government funding levels that were not keeping up with a fast growing population. The ACT allocated mental health funding of approximately $23 per head of population in comparison with the NSW figure of $35.[71] Hughson noted that without additional resources, ACT Mental Health Services were forced to:

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[70] In the *ACT Health Annual Report 2002-03*, it was reported that 50 acute care beds were available in public facilities (ACT Health 2003). In the *2003 Annual Report for ACT Mental Health Official Visitors*, it is noted that, due to staff shortages, only 44-46 of the 50 beds were available for use (ACT Mental Health Official Visitors 2003:5).

[71] Fifteen years later, the ACT Government provided $67.38 per capita in comparison with the national average of $81.80 (ACT Mental Health Official Visitors 2003:5).

> accept the narrow definition of mental health, and this is done primarily for reasons based in pragmatic considerations of resources, and not for philosophical preference (Hughson 1986:3).

What he meant by 'narrow' was that persons eligible for mental health care and treatment were principally 'the acute psychotic patient, and those disabled by previous episodes of psychotic illness, the more severe neurotic forms of illness … and a range of disorders in children (Hughson 1986:3). This narrowing of service provision contrasts with Dax's broader vision of psychiatric care for the psychotic, the neurotic, the geriatric, the sociopathic, the intellectually deficient and the child with psychiatric issues that he articulated in 1962.

Hughson also questioned whether persons with personality dis-orders would benefit from psychiatric treatment or whether 'there is within this an aspect of social control' (Hughson 1986:4). In his view, the *needs* of the 'socially dysfunctional' were not appropriately addressed by hospitalisation because their behaviour was regarded as a consequence of personality type or social factors, and medical treatment was therefore not immediately efficacious or appropriate. They were also a drain on the limited resources of the psychiatric ward.

The challenge of meeting different psychiatric *need*s of a fast growing population was a theme that continued in public policy discourses of the 1980s. Hughson refers to complaints received by Mental Health Services over a six month period, including 'lack of counselling staff, lack of inpatient psychiatry beds, inadequate day activities centres, absence of community mental health nurses, insufficient supervised accommodation for disabled mentally ill'. He also acknowledged the difficulties of recruiting and retaining clinical staff (Hughson 1986:2).

When I entered the community my research, geographical and organisational divisions between repressive and rehabilitative, medical and non-medical treatment and care were noticeable. Furthermore, different understandings of, and meanings attributed to, 'community' emerged in the course of interviews with consumers, carers and workers, in group discussions and public meetings. Arising out of these differences was the recurring theme of a tension between organisational roles and responsibilities.

The fields of 'community'

In common with other key words, 'community' is persuasive yet problematic, vague and ambiguous. The very promiscuity of key words contributes to their polyvalence and incoherence (Comaroff & Comaroff 1999:8). During fieldwork, 'community' emerged as a geographical place in which people resided; as a maze of diverse services and activities relating to the fluctuating needs of consumers; and as a space occupied by the non-government organisation (NGO) in opposition to government. For the purpose of this chapter, 'community' is defined as mental health services and activities involving an assortment of agents and agencies, including state agencies, that do the work of government on a funded or voluntary basis.[72] This broader understanding of 'community' is similar to that of a sector, defined by Rowse as an organisational entity which is neither the state nor civil society, but is a creation of interactions – 'sometimes, but not always, frictional' – between government and a particular sociocultural, economic 'domain' (Rowse 2005: 2).

Consumers used 'community' to refer to the range of mental health services and activities (the mental health *system*) as well as a place in which they resided. While they valued the freedom of living in the 'community' (as opposed to confinement within the asylum), the risks of isolation, loneliness, poverty, stigma and discrimination were also acknowledged. Mental health geographers have similarly conceptualised 'community' by tracing the lived experiences of consumers in their built environments. Researchers have undertaken field studies in North America and Great Britain that map the daily lives of psychiatrically dis-ordered bodies across diverse spaces of community (Dear and Wolch 1987; Wolch and Dear 1993; Wolch, Rahimian and Koegel 1993; Butler and Parr 1999; Knowles 2000; Parr 2000; Pinfold 2000). The promise of community integration and acceptance has been evaluated in studies on how neighbourhoods respond to psychiatrically dis-ordered persons living in their localities. Using both qualitative and quantitative methodologies, researchers have mapped a landscape of 'accepting' and 'rejecting' neighbourhoods (Wolch and Philo 2000:140). Within these neighbourhoods, 'community' is experienced as a complex landscape of contingent and fragmented spaces where:

> (l)ives are not lived in place but in the threading together of places as sequential scenes in their trajectories ... movements in and out of the revolving door of the local psychiatric wards ... movements between places to live, eat and get psychiatric help. (Knowles 2000:217, 219)

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[72] The family unit, usually referred to as *carers*, is also a member of this community or mental health sector, and the historical roles played by the family and carer in the management of psychiatric dis-order are discussed in greater detail in Section III, Relationships of Care.

Findings reveal that rejecting neighbourhoods are more likely to be located in middle-class, nuclear family suburbia where 'residents were suspicious of nonconformist behaviour' (Wolch and Philo 2000:141). A study by Holden, Lacey and Monach into local views on the development of secure mental health facilities in a North England community found that the closer residents were located to a planned facility, the more they were likely to resist development (Holden *et al* 2001). Due to public opposition, two of the four facilities were not built. The authors noted that:

> (t)he location of the unit in the community reflected the policy of locating the care of mentally ill people within a community context, as part of the rehabilitation and reintegration process. This was not something that the residents seemed to accept and this may reflect a conflict between the priorities of the managers' need to integrate patients into the community and the residents' need for reassurance on safety (Holden *et al* 2001:518).

Rejecting neighbourhoods may also react to the individual person who is showing signs of strange or irrational behaviour. Tanya lives in a quiet, well-kept and neatly manicured neighbourhood in Canberra suburbia. Her adult son, who was living with her at the time, experienced his first episode of psychosis on a weekend when she was out of town. Tanya described how Joshua came to the neighbours' attention when he:

> *went in, entered into that person's backyard ... pretended to eat food out of the dogs' bowls to be like the dogs so that the dogs would sort of relate to him and have some sort of connection with him so he could calm them down and stop them from barking. So when the neighbours saw that, and they saw an elderly woman* [one of Joshua's relatives] *running across the* [neighbourhood] *field, they called the police. Police arrived in three vehicles. Mental health crisis workers also arrived. The police were very rough with him. ... One police officer apparently just grabbed him and threw him up against the paddy wagon.*

On that occasion, Joshua was taken to PSU and released after ten days' treatment and care.

Rejecting neighbours may force the removal of the psychiatrically disordered from their streets by other means. Gerard's son was evicted from his accommodation after his neighbours made numerous complaints to ACT Housing. Gerard typified his son's life at the time as one of *chaos and mayhem*. He would, for example, leave his kitchen stove turned on for days, unattended. He would play loud music for days on end. At the time of our interview, Gerard's son was under an Order to reside in a secure care facility.

Accepting neighbourhoods, also referred to as 'psychiatric ghettos', tend to be located in the inner city, in medium and high-density public housing complexes (Wolch and Philo 2000:140). The ghettoisation of the psychiatrically dis-ordered is a process that is not only connected to their finding an acceptance of sorts within a particular spatial setting. It may also be determined by their proximity to mental health services. Drawing on their research in North America, Dear and Wolch describe the ‘psychiatric ghetto’ as typically one:

> where support services and housing opportunities are available. ... service providers find most of their clientele and the least community opposition to the service-dependent and their facilities .... concentrated in the oldest and most deteriorated part of the inner city. (Dear and Wolch 1987:248)

In the relatively new and planned city of Canberra, pockets of psychiatric ghettos are found in medium density public housing settlements. In these neighbourhoods, cultural Others co-exist with those who live on the social margins of society. While the strange behaviours of the psychiatrically dis-ordered may not be subject to the judgement of rejecting neighbourhoods, living in a psychiatric ghetto tends to result in a different kind of hardship, as Jane discovered:

> *This is an environment that can be really depressing. Poverty – scary people – drug culture – domestic violence. ... In the time I have been here there have been four tenants who have sold drugs ... Plus over Easter this year people bought drugs in another block and came in this stairwell to shoot up. Vomit on the stairs. Terrifying people shooting up on stairs. All sorts of problems. They even came in my courtyard ... Low rent helps heaps but everything else compounds the problems you already have, e.g. PTSD, anxiety, social isolation.* (Jane)

All informants acknowledged that the diverse range of services available in the community created confusion for both clients and service-providers. Negotiating the parts that make up the community was regarded as a baffling and bewildering pastime. For example, NGOs operate in an uncertain funding environment. Organisations may fragment and proliferate, shift in form and function as existing services are de-funded and reconfigured while new services emerge. Consequently, pathways that in a functionalist world would consistently connect to a whole are difficult to establish and maintain. At times, then, it is more appropriate to imagine the community as a ‘squirming and changing psychedelic labyrinth’ rather than as a comprehensible governmental setting (Gudorf, cited in Angrosino 1998:29).

It is possible to map the community through its rationales of care, for underpinning this confusing labyrinth of service provision are the spaces for confinement and recovery and the spaces of medical and non-medical treatment and care, reflective of consumers’ diverse *needs* and capacities. While in the asylum these *needs* and capacities remained encompassed within the perimeters of its boundaries and contained within wards with different functions, in the fractured spaces of the community *needs* and capacities are being met in dispersed locales. The moral architecture of asylum wards such as the Recent and Acute, the Intermediate, the Quiet and Industrious, the *back wards* for the chronically unwell, and micro-spaces including the Seclusion Room, the Day Room and Occupational Therapy Workshop, have been dislocated and reconfigured in the fragmented and diverse moral spaces of facilitative and punitive communities.

NGO informants tended to emphasise a division along the lines of organisational function. At the same time as these informants acknowledged the important roles played by government and NGO workers, they also associated the institutional settings of government with repressive and rigid practices, and those of the non-government sector with rehabilitative and inclusive programs. A theme emerged during interviews with NGO workers, where the non-government organisation was tended to be described as *a place where people will be healed,* where growth and recovery take place in opposition to a clinical setting such as the PSU, a place for *consumers in crisis.* Implicit in the distinction made by NGO informants is the suggestion that healing takes place through participation in the activities and programs of the NGO, while the psychiatric ward functions as a space for the stabilisation and control of symptoms of psychopathology. In addition, NGO workers tended also to equate a particular kind of ‘community’ with their organisational type, and distinguish it from the work of government.

Community was conceptualised by NGO informants within a binary frame of authoritarian vs. egalitarian structures, clinical vs. non-clinical treatments, and atomistic/individualistic vs. relational values. The theme of a gendered division of labour, which associates government with male-ness and non-government with female-ness emerged, whereby research participants contrasted community NGOs, female spaces of caring, with masculine attributes of the *system*. Some workers used the association of a gendered community, of NGOs engaged in undervalued women’s work, as a way of explaining their lack of funding, low salary levels and unstable working conditions. The precarious funding environment in which NGOs struggle to sustain their financial viability may have impacted on informants’ perceptions of their at times oppositional relations with a government in control of the ‘purse strings’ and secondly, on their evaluation of the different functions of government and non-government sectors.

NGO workers drew on gender constructs to describe the unequal power relations that they believe permeate the sector, between medical and non-medical spheres that privilege (individualistic and atomistic male) biomedical knowledge and practice over the practices of (relational female) social welfare. Clinicians, I was told, did not have the time (or interest) to consider the *needs* of the whole person in a social context and therefore provided little more than pharmaceutical solutions. Consumers turned to community programs to have their social and/or rehabilitative *needs* met. The *non-clinical* work of an NGO was emphasised by a worker who described the importance of overcoming the separating effect between *them and us*, between the pathological and the normal. One strategy this NGO used for building *an inviting and welcoming community* was the decision not to use the language of biomedicine. A worker in another NGO described the importance of operating under an *ethic of kindness* where clients can experience acceptance and *a sense of belongingness*.

Informants from the NGO sector divided the community into a masculine sphere of government whose agents were authorised to mobilise the arts of repressive care, and a female, non-governmental or ‘community’ setting whose agents were associated with the arts of rehabilitation. Not surprisingly, a wedge between repressive and rehabilitative roles and medical and non-medical functions of psychiatric services and NGOs at times manifested itself in misunderstandings and tensions between service-providers.

Debbie’s advocacy on behalf of her client who had been diagnosed with borderline personality disorder included putting in an application for a treatment plan. She had hoped to make a plan with the mental health professional and in consultation with the client. What resulted was a treatment plan made by the mental health worker without consultation with the client. *You would think*, Debbie suggested*, that if you want clients to co-operate with a plan you would try to engage with them, find out what works for them. Commonsense would dictate such a response.* However, this did not happen and Debbie’s client now has a treatment plan which is not about her, and is not reflective of her lifestyle.

The tensions between the different service areas of the community are not new: thirty years earlier Hennessy wrote of the need for closer working relations between ‘acute hospital units and the community mental health services’:

> This problem of the relationship between hospital and community services has not yet been solved in any part of the health field here or elsewhere. (Hennessy 1972:37)

Further insight into the context that has been creative of the binary of government and community is provided by drawing on Sawer's work on the 'gendered metaphors associated with central liberal ideas of the state' (Sawer 2003:87). In her historical account of twentieth-century liberalism, Sawer describes how the state has been imagined in gendered terms that have been overlaid onto the binary of the minimal versus the welfare state. The feminisation of the state has been attributed by critics to the extension of state functions. The influence of feminine norms of caring, nurturing, and over-protectiveness have been associated with a 'nanny state', a state with breasts. In this discursive domain, citizens have been encouraged to wean themselves off the teat and embrace the masculine values of independence, competitiveness and individualism. Turning to the work of Carol Johnson, Sawer describes a process of 'dematernalising' in the 1990s, where a 'hard masculine identity' of the public arena was cast in opposition to the private sphere of the family as 'site of feminised values of nurturing and caring' (Johnson 1993, in Sawer 2003:100). Sawer also makes links between these feminine values with those of the non-government sector (Sawer 2003:93).

Sawer's writings suggest that the non-government sector may be correlated with the values of caring and nurturing, a view that is congruent with those of the NGO workers who participated in my research project. In this analytical space, the government – or state – is associated with an authoritarian form of hard masculinity that, for example, permeates the rules and procedures of PSU; and is available to police officers authorised to bring in reluctant and recalcitrant consumers, to clinical staff authorised to impose diagnoses and periods of detention and seclusion upon patients, and to ward *henchmen*, authorised to physically contain, detain and remove them.

In the next section, the theme of a community organised along the binary of repression/rehabilitation is sustained by borrowing from the writings of Cass and Brennan. While I acknowledge the limitations of reifying the fluid, contingent spaces of regulation and restoration, the analytical terms of 'communities as enabling and facilitative' and 'communities as spaces for surveillance and enforcement' are useful tools for conceptualising some of the physical and social landscapes of the Canberra mental health community (Cass and Brennan 2002). Enabling communities tend to evoke the therapeutic setting of Arcadia, drawing on the calmative properties of nature and the creative arts to effect the recovery of the psychiatrically dis-ordered. In contrast, repressive communities emerge as spaces for managing the Barbarian primitive, the ‘unpredictable’ subject existing without culture who is ‘associated with degeneration, disruption and pathogenesis’ (Lucas and Barrett 1995:289,315).

Mapping the Landscapes of Community

During fieldwork, I discovered a plethora of organisations and activities representative of consumers’ diverse *needs* and capacities. Mental Health ACT, a separate division under ACT Health since 2003, funds clinical as well as non-clinical services. In 2002-03, it provided services to 6,102 people, including 1,361 acute inpatient admissions (ACT Health 2004). Twenty NGOs were funded $3.4 million to provide ‘education, advocacy, information and referral services, supported accommodation and respite programs, psychosocial and recreational programs, counselling and support programs, individual funding arrangements for consumers with complex needs’ (ACT Health 2004:18).

The following spaces for community are mapped by examining some of the built forms of ‘human warehousing facilities’ and semi-institutional places of Canberra (Knowles 2000; Parr 2000). Noticeably lacking in this mapping exercise are the community mental health services in the town centres of Belconnen, City, Woden and Tuggeranong, the general practitioners and other private health professionals who together represent the largest group of mental health service providers in the ACT. A comprehensive ‘threading together of places’ in consumers’ trajectories would necessarily provide coverage of *all* ‘movements in and out of the revolving door of the local psychiatric wards ... movements between places to live, eat and get psychiatric help’ (Knowles 2000:217, 219). However, it was beyond the time and resources of my project to thread together all consumer mental health movements in Canberra, and my analysis of the following spaces for community is necessarily partial and illustrative rather than comprehensive.

Only five of the 20 NGOs funded by Mental Health ACT are featured. These NGOs were selected on the basis of invitations I received to visit their sites of rehabilitation. At my request, I was taken on a ‘tour’ of the private psychiatric hospital, Hyson Green. The private ward is featured to illustrate its divergence from PSU, in terms of patient profile, environmental setting and staff-patient relationships. The ‘communities of surveillance and enforcement’ were not selected on the basis of any invitation but for reasons based firstly, on concerns expressed by informants regarding the repressive culture of PSU; and secondly, on a personal decision to broaden analytical scope by featuring an accommodation facility with spaces for secure care and seclusion, in the Brian Hennessy Rehabilitation Centre.

The community in which I undertook fieldwork in 2002-04 was described by Official Visitors as ‘a system under stress’:

> mental health services in the ACT are struggling to cope with the increasing demands placed on them. While we visit only in-patient facilities, we see some of the impact on these services from pressures on community based treatment and support services. We also hear consistently, stories from consumers and carers about the limitations of community based services (ACT Mental Health Official Visitors 2003:5).

For inpatient facilities, this ‘stress’ was attributed to a number of factors, including clinical staff shortages resulting in bed restrictions (PSU operated at four below a capacity of 30 and Ward 2N two to four beds below its capacity of 20 beds); high occupancy rates resulting in high bed turnovers of recovering patients; multiple admissions; quality and safety issues; and lack of recreation, occupation, education, training and rehabilitation programs [in a treatment environment that emphasises medication] (ACT Mental Health Official Visitors 2003:5-8).

Community as enabling and facilitative

Ainslie Village

Ainslie Village may be described as a ‘human warehousing facility’. Ainslie Village offers boarding style, shared accommodation in barrack style houses for approximately 190 residents (Tania Parkes Consulting 2002:12).[73] Its role is not to impose structured routines on its main body of residents and nor does it seek to curtail their liberties. If any resident becomes disruptive and is not willing to abide by the rules, he or she is asked to leave.

At least 50% of its residents have been formally diagnosed with a psychiatric dis-order, about 83% have drug issues, and 35% have problems with frequent and/or excessive alcohol use. A staggering 25% of residents who have been formally diagnosed with a psychiatric dis-order are living with

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[73] There is some segregation of categories of residents. For example, the Lodge (a building located on its grounds) accommodates men who need a higher level of support for *complex needs*. The role of the Lodge is discussed in greater detail in Chapter 12.

schizophrenia. Most residents are aged between 26-55 years and men outnumber women 85:15. Approximately 60% of the residents have lived there for more than a year, 34% up to five years, and 26% for more than five years (Tania Parkes Consulting 2002:18-20).

A worker provided anecdotal evidence that the Village accommodates some of the former inmates of Kenmore and former residents of ACT Watson Hostel, whose psychiatric histories also link them to Kenmore, for whom deinstitutionalisation has not worked, who do not have ‘the skills or capacity to negotiate the hurdles of independent living’, but for whom the Village offers a sanctuary of acceptance (Tania Parkes Consulting 2002:35).

A description of the Village geography evokes nineteenth-century views of the role of moral architecture in asylum design. The Village is:

> set on a sloping site of 3.9 hectares at the foot of Mount Ainslie. Landscaping is sympathetic to the native flora of Mount Ainslie and contributes significantly to the amenity of the site. There is a watercourse that uses the slope of the hill to channel storm water through a series of ponds to a dam at the lowest point. Shrubs, trees and landscaping features provide shaded areas for summer and sheltered sunny spaces for winter that contribute a quality of calm to the site. ... There is a small timber pergola at the rear of each house. ... covered walkways connect the main areas of the Village. ... The natural environment intrinsic to the open site design ... is calming and aids healing. (Tania Parkes Consulting 2002:12,35)

Within this physical landscape, a closed community provides residents with social contact and activities in an environment that is accepting of difference:

> The Blue Door provides free food and hot beverages during opening hours. ...The three paid staff at the Blue Door provide a basic haircutting service when time allows, and clothing and furniture vouchers to the St Vincent de Paul charity shops. ... The Blue Door offers a point of social connection for residents, some of who would not otherwise venture out of their houses. For some residents, a haircut is a rare opportunity to be physically touched by another person in an acceptable way. Some residents spend all their time at the Blue Door. Free access to food and hot beverage has a calming effect on volatile residents ...
> Although some residents say they look forward to moving to more independent accommodation, on further investigation it emerges they have had that opportunity but have chosen to remain at the Village. It is not only the free food and cheap rent that attracts residents: it is access to 24 hour support, the attractive design of the site, the sense of community and anonymity of being one among many. ...
> Those who choose not to communicate beyond what is essential, express a sense of comfort and acceptance being among people who understand them. ... (Tania Parkes Consulting 2002:12-15)

Notwithstanding the therapeutic intents and effects of Ainslie Village, the Report notes incidents of drug dealing, theft, vandalism and violence. It recommends more activities, and the replacement of damaged or stolen furniture (Tania Parkes Consulting 2002). Due to its association with ‘social junk’, with the irresponsible and the untrustworthy, the drug dealers and petty criminals, the mentally disturbed and the down and out, the Village is widely regarded as a stigmatised environment:

> Some homeless people see it as the last resort and resist referral to the site. Residents applying for employment rarely provide Ainslie Village as their residential address for fear of discrimination. (Tania Parkes Consulting 2002:19)

Inanna

Inanna was described by its staff as an organisation for *women in distress*. It is located in a quiet suburban street and consists of a free standing house with rooms allocated for office and support workers, and spaces set aside for formal meetings as well as social get-togethers. Accommodation units have been constructed in a spacious yard at the rear of the property. The buildings of Inanna are surrounded by well-kept, landscaped gardens. Open courtyards and more private spaces for workers and clients have been created. An art studio is also located in the garden. In addition to running psychosocial rehabilitation programs, Inanna regularly provides art as therapy workshops.

Established approximately 20 years ago, Inanna's organisational philosophy is based on community development and feminist principles in combination with a narrative therapy approach. Organisational values of listening and inclusiveness are realised in consensus decision-making processes that focus on flexible agreements rather than rules, and the celebration of difference. These values are reflected in their client profile. According to its workers, Inanna attracts *bad* women, *stroppy* women including those with Borderline Personality Disorder whom the *system* has failed and/or rejected. There was also anecdotal evidence that Inanna's inclusiveness attracts a higher proportion of non-English speaking and Indigenous women in comparison with other mental health organisations in the ACT.

Well-being is promoted by *offering a facilitative community* through Inanna's program of activities, through communal events and public celebrations. At the time of my research, the organisation managed facilities for four respite, four supported accommodation, and 12 homeless women. Inanna also provided outreach support for approximately 25-30 women living in the community and ran a 'Women for better Mental Health' newsletter.

Inanna's physical geography actively promotes healing and recovery. The garden utilises aspects of Asian and Australian Aboriginal cultural knowledge in its design. A range of culturally diverse objects are scattered throughout the gardens and the buildings, to foster a welcoming and inclusive environmental setting. There are also outdoor installations created by clients as part of the art as therapy workshops. In addition to sitting quietly in private spaces created within the garden, workers and clients can sit individually or more socially as a group on a *joggling board*, for relaxation and rhythm. Spaces for clients' children have been created in outdoor play settings and an activities room. There is a vegetable garden and other outdoor pastimes available for those clients who enjoy working in a garden.

A prominent feature in the garden is a stand-alone, 12 sided wooden structure. It is a quiet space wherein clients can do *interior work* in the form of writing and meditation. Light filters through four windows and a skylight. The wooden walls have been stained and the floor is carpeted. Large cushions are available for relaxed, informal seating arrangements.

Inside the main house, I was struck by the use of colour. Each room has a feature wall painted in bright green, purple or orange. The furniture and art work complement the colour scheme. Candles, Asian artefacts, tranquil music are suggestive of a calm and peaceful environment. In addition to creating an aesthetically pleasing setting, Inanna promotes the values of orderliness and tidiness. When clients' lives are dis-ordered, a worker told me, a tidy and clean environment provides a calming and stabilising balance.

Warren I'Anson House

At the time of fieldwork, Canberra had one respite care facility for consumers who need a reprieve from their usual circumstances. Situated in a quiet, tree-lined suburb, the Warren I'Anson House is named after a consumer who was shot and killed in his own home by police responding to community concerns about his potentially suicidal behaviour.

Respite care may be requested by consumers or by workers in supported accommodation facilities. Therefore, the consumer may have requested the respite, or he may have been ordered to spend a few days at the facility. Other grounds for respite might be as a temporary accommodation solution while the client's clinical case manager organises something more long-term.

Usually, clients seek access to the respite facility when they are *starting to feel things are getting on top of them*. This often relates to their living arrangements. Drawing on their own experiences, the two respite care workers I interviewed believe that many consumers living in congregate public accommodation facilities do not feel safe or secure and that this has a negative effect on their mental well-being. I was told that consumers tend to be *vulnerable to predators*. They referred to several cases where people had taken over clients' flats. Congregate accommodation facilities for the poor and the disadvantaged also tend to be more susceptible to burglary by other tenants and/or their associates needing money and goods to finance their drug habits. Consumers may themselves have drug and alcohol issues and living in such a setting may exacerbate or encourage their addictions.

Generally, clients can stay in respite care for a maximum of two weeks. There is a social focus in the House, with outings to the movies, etc., depending on the clients' interests. Clients are encouraged to treat their time in the home-like, stable environment of the House as a holiday. I was also told that, in contrast to the clinical priorities that permeate the psychiatric ward, it is important for workers that their clients enjoy their first stay in the House.

Richmond Fellowship

Originally established in England in the late 1950s, (Bloor *et al*) the Richmond Fellowship has expanded into an international network of organisations. Its philosophy may loosely be described *as helping the disadvantaged.* Each organisation has some autonomy in terms of funding arrangements and organisational structure. In the ACT, the Fellowship is 100% reliant on government funding, and is focused on providing services for persons with mental health problems. It is not through the power of design features of the physical organisation itself but through the support, guidance and training clients receive from Richmond Fellowship workers that assist them in creating and maintaining a therapeutic environment and sense of well-being.

As part of *helping the disadvantaged*, workers actively create a moral environment by normalising and integrating clients in a home-like atmosphere. At the time of fieldwork, the Fellowship managed four group houses. It also provided counselling services and outreach support for approximately 35 clients in independent living skills in the community. Fellowship workers also facilitated social interaction between clients, by organising get-togethers over coffee or excursions.

One of the workers I interviewed did not correlate these activities with community-building because there was not

> *necessarily a feeling of community amongst our clients in general. They reside together bound by a need for accommodation and an, often, uncertain diagnosis. Although we provide many opportunities for social interaction, I don't think we've created a genuine "sense of belonging".*

The equation of 'community' with a sense of belonging is a reminder of the problematics of the term, as vague and ambiguous in definitional scope. The worker's view of the limits of community-building may be related to clients' mobile trajectories, of moving through the Fellowship's accommodation facilities as alternative accommodation becomes available. The worker's view may also be based on a common perspective amongst NGOs, of the meaning of community as a space of belonging and relatedness. However, whatever limitations of community-building exist for both workers and their clients, the organisation is fulfilling the objective of care in community by addressing the accommodation *needs* of consumers.

The Rainbow Room

The Rainbow Room is a psychiatric enclave located in a northern suburb, in a convoluted complex that formerly functioned as a high school and is now a site used by a range of different organisations. Its physical geography sets it apart from the plethora of other organisations located in the complex known as Canberra Technology Park. Unlike the other occupants of the former Watson High School, the Rainbow has established an extensive garden and its walls and furnishings are, like its name, decorated in the colours of a rainbow.

Described as a psychosocial rehabilitation centre, the Rainbow aims to *normalise people within the community* by running vocational, non-vocational and living skills development programs and social activities for 350 members. These include computer and administration training, arts and crafts, gardening, communication and living skills including cooking, cleaning and resumé writing. At the time of fieldwork, the Rainbow also ran a support group for people living with schizophrenia and a substance use and recovery program.

The symbolism of inclusiveness, as is suggested by the rainbow, is articulated in motherhood statements of the Rainbow's aims, which are conspicuously pinned onto a large noticeboard in the central living area:

> The Centre will provide an environment that accepts all mental health consumers

> A place where we can be ourselves
> A safe and accepting place
> An arena where stigma and discrimination are broken down

The physical and social environment is thus used to signify inclusiveness and healing. Implicit in its therapeutic design features is a message, in the words of one member, *there is a space for everyone*.

The Rainbow's interior spaces consist of a large, open-plan hall and smaller, private spaces in adjourning rooms for conducting meetings and classes. There is also a kitchen, a room for a full-sized billiard table, a music and exercise room, and an art studio. The large hall, in addition to being brightly decorated, includes an array of formal and informal seating arrangements. These are broken up into separate spheres by the placement of bookcases and screens.

These environmental arrangements, the availability of books, games, tea and coffee making facilities, outdoor smoking facilities and garden seating, in addition to the wide array of planned activities, give members the choice and flexibility around how social they wish to be. For some consumers, the Rainbow functions as a destination point for demonstrating their membership of a social group. For the consumer who has recently been discharged from the psychiatric ward, the physical efforts of catching public transport while coming to terms with medication side-effects can be overwhelming, constraining their ability to participate in group activities. For these members, at this early stage in their recovery process, the Rainbow functions as a place in which they may spend time dozing on one of its many sofas.

Members of the Rainbow referred to it as an accepting place: *here you can be yourself*. Sam described the Rainbow as a *Day Room*, with functions similar to those found in a psychiatric facility, including the asylum. He also described the Rainbow as *our place.* Other members commented on the sense of belonging induced by the Rainbow: it offered *consumers somewhere to go*, to *make friends* and *explore talents*, a place that also provides them with a *good meal, trips away once a month*.

Hyson Green, Calvary Hospital

Calvary Private Hospital is described as 'situated in a bush land setting on the north side of the nation's capital, Canberra, ACT.' Hyson Green provides mental health care and offers 'premier facilities including single rooms, single rooms with an ensuite, executive suite accommodation.'[74] Staff were happy to take me on a tour of the 20-bed unit and were open to questions about care and treatment issues. While there is no doubt that Hyson Green provides a hospital service and issues of safety and risk management are embedded in its policies and procedures, these are not overtly visible and the setting is more reminiscent of a holiday resort. I was reminded of the beautiful and calm environmental setting of Hyson Green six months later during a tour of the Retreat in England. Although the Quaker hospital caters to public patients, in particular difficult to place clients of the National Health Service, only those consumers with private health insurance can afford the Arcadian setting of Hyson Green.

In a private courtyard, patients can relax and enjoy some of the tranquil and soothing aspects of nature, including landscaped gardens and a water feature. A cafeteria provides meals, offering patients a wide variety of choice in their diet. Relaxation techniques including massage are available, and a key principle of care is the importance attributed by management to the therapeutic relationship between a nurse and his or her patient. Hyson Green caters for voluntary patients.[75] It is the in-patient facility of choice for Nora, who told me that of the three in-patient facilities available in the ACT, Hyson Green's environment is the most conducive to her *healing process*. As a private health care provider, Hyson Green is not a choice that is available to many mental health 'consumers'.

A community of surveillance and enforcement

The Psychiatric Services Unit (PSU)

> Patients do notice good quality design and this improves patient dignity and self-image assisting them with their recovery.[76]

PSU is a facility for acutely ill mental health consumers. Its primary function is described as stabilisation through 'short-term treatment and care' in a safe environment (Mann and Laroche 2003:7). A review of the design and operation of PSU was conducted in 2002-2003 in response to three patient deaths over a 14 month period (Mann and Laroche 2003). Governmental technologies for

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[74] http://www.calvary-act.com.au/private.html, accessed November 2008. A similar search on the internet for information about the public psychiatric facility, the Psychiatric Services Unit, turned up accounts of adverse events and governmental reviews.

[75] Ward 2N in Calvary Hospital is a public ward and is the other in-patient facility that caters only for voluntary patients.

[76] One of the findings of a literature review of the impact of the built and natural environments on quality of life and clinical outcomes for patients (NSW Health 2005:2). The lack of quality design in PSU and its impact on safety and wellbeing has been an ongoing concern.

managing the *needs* of the acutely ill manifest themselves in a culture of intensive care and treatment. The language of risk and surveillance permeate its spaces, for PSU caters for the unpredictable, the violent and the self-destructive. As soon as their condition reaches an acceptable risk level, the psychiatrically dis-ordered are discharged into the community. This may take place before their medication has been given time to take effect.

At any given time, approximately two-thirds of PSU's admissions are involuntary 'patients'. In a previous chapter it was noted that the asylum occupied an unstable place between prison and hospital. While PSU is situated in a hospital, its architecture more closely resembles that of a prison. There are also contradictions between its form and function, creating a belief among both staff and patients that, in contrast to its objectives, PSU is an unsafe environment. The following is a composite of descriptions from the report prepared by Mann and Laroche, and (italicised) excerpts of discussions with community workers, carers and consumers as well as an account of my experience as a visitor to the facility:

> *Entrance to the ward is always locked.* A locked unit creates a strong impression of containment and distances visitors and relatives (Mann and Laroche 2003:9). *Upon arrival, one is required to press a button and state the purpose of one's visit. A nurse at the nurses' station, or 'Glass Bubble' as it is referred to by some because of its resemblance to a glass bowl, may electronically release the lock. It is approximately 20 metres' distance from the front door to the 'Glass Bubble'.* Several people described it as a "bunker" (Mann and Laroche 2003:11). *Once inside, one is almost overpowered by the atmosphere, although people may respond differently according to their level of sensitivity. There are two windows at the 'Glass Bubble', one for the receptionist and the other for the nursing staff. It is not unusual to be kept waiting for five minutes before receiving attention. ...* carers and consumers ... described many instances of waiting for extended periods of time and felt largely ignored (Mann and Laroche 2003:11).
>
> The major functional areas of the unit include a general ward area designed around three central courtyards, one of which was not in use due to reduced staffing levels. Patient accommodation is on the external perimeters of the building and is designed as semi self-contained modules providing single and double rooms. Each module ... include a small number of beds, generally around 4-5, a dining/lounge area and toilet/bathroom facilities. The suites are connected by a series of corridors that run in a grid throughout the unit. (Mann and Laroche 2003**:**7-8)
>
> *The ward is divided between upstairs and downstairs spaces, reflective of divisions of organisational functions as well as status. Upstairs is a series of spaces reserved for doctors, senior nurses and admin officers, and a tearoom. It is a quiet, clean and safe space, referred to as the haven, in stark contrast with what is happening downstairs. Entrance to upstairs spaces is locked. Downstairs, nurses have access to another haven – the Glass Bubble –protection, safety and security are provided by its locking facility. The Glass Bubble is a downstairs haven surrounded by the chaos of madness.*

> *PSU is a locked ward within which there are other locked wards, including High Dependency Units and four Seclusion Rooms.* Each HDU (one each for men and women) consists of five beds staffed at all times by two nurses. The furniture in the HDU conveys an impression of a custodial setting as it is oversized and fixed to the floor. The HDU courtyards (and others as well) are barren and hot with hard brick and paved surfaces creating a stark custodial-like environment. There is an absence of a garden area that would soften the environment (Mann and Laroche 2003:12-13).
>
> *The architectural layout of the ward consists of small areas that are secluded.* Whilst clear sight lines to patient areas are not always possible ... this particular Unit appears to have been designed with the opposite in mind, designing sightlines out. ... It is clear that it is very difficult, if not impossible, to undertake visual observation of patients on the unit from central vantage points. ... It is more reminiscent of a rehabilitation unit than an acute inpatient unit where patients are encouraged to have greater independence and are less acutely ill. It appeared to the reviewers that the design philosophy was to create small personal spaces that promote personal privacy (Mann and Laroche 2003:10). *I was told that design limitations of the ward represent a safety issue for patients as well as staff.*
>
> *The décor of the seclusion room has not changed from that of its asylum origins: each room contains a mattress on the floor and a bedpan. Patients who stir up trouble, who are too high, too angry, too anything, are sent to this time-out facility.*[77] *The asylum practice of seclusion continues to be mobilised, for several hours, for several days, and occasionally – for the aggressive and violent patient - for several weeks.* The seclusion rooms in the reviewer's opinion are inappropriately sited. They are not easily accessed from the HDU where most instances of seclusion will be required. Any transfer to the seclusion rooms from HDU requires movement through a patient area, Suite C. This suite is used predominantly for female patients and escorting a disturbed patient through the lounge area is both confronting to those observing this and lacks privacy for the individual concerned (Mann and Laroche 2003:13) *Consumers described the distressing experience of hearing screams, of seeing people being dragged down corridors by henchmen.*

As becomes obvious from the above description, the classification and segregation of patients according to age, gender or diagnosis is not possible in the confines of a 30-bed psychiatric ward. Patients with different needs mix in the same ward. It is not unusual, therefore, for a 15-year-old psychotic male to interact with a 79-year-old depressed female suffering dementia. For many, this mixing of patients can be a traumatising experience. A young person admitted with depression for the first time could find it personally distressful coming into contact with older, chronically psychotic patients: *you could lose all hope* by starting to believe, *that's how you're going to end up* (Louise, a consumer and interview participant).

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[77] Official Visitors reported they had received claims 'that decisions to move to the high dependency or seclusion areas are not always made solely on clinical grounds' (ACT Mental Health Official Visitors 2003:10).

In view of the legal authority vested in PSU to involuntarily detain and treat people, it is not surprising that informants, including service-providers, carers and consumers, described the ward in terms of the overarching power they believed it exercised over people's lives. There was a belief that people could go into the ward voluntarily but that their legal status could easily be changed: *they can do what they like with you and the paperwork gets done later.*

In response to their experiences of involuntary hospitalisation, consumers reflected on the sense of powerlessness they felt in their dealings with the psychiatric facility. Most were discharged feeling more traumatised as a consequence of their involuntary detention and treatment, described as dehumanising and punitive, than from the symptoms of their psychiatric dis-order. Contrary to its formally stated functions, PSU was almost invariably described by consumers, carers and NGO workers as *an unhealthy place, a crazy-making place.*[78]

The Brian Hennessy Rehabilitation Centre (BHRC)

The BHRC comprises two 10-bed villas and a 'locked, but not secure' 10 bed unit that also contains a seclusion room (ACT Mental Health Official Visitors 2003:16). In 2001 I attended a presentation by some of its staff at a meeting of a local NGO. In the hand-out provided at the meeting, the BHRC is described as a facility for persons

> who have unremitting and severe symptoms that prevent them from living in a less restrictive environment. This facility is able to manage consumers who are on involuntary orders …

In response to questions from the audience, staff commented that an average length of stay at BHRC is six to nine months. The typical resident was described as someone living with chronic schizophrenia, schizo-affective disorder(s), other psychoses, or 'manic depression'. BHRC residents are described by Official Visitors as 'seriously disabled' (2003:16). Persons who are 'non-compliant with treatment', who represent a 'serious absconding risk' or who have 'disturbances of behaviour that present a risk to self or others' meet the admissions criteria for the Secure Care Unit.

In their report, Official Visitors noted that as a consequence of their disability, many of the residents are limited in 'their capacity and confidence to

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[78] For these reasons, I sought and was given access to interview PSU staff. One staff member responded to my request for interview participants.

raise concerns' (2003:16). The issues that were usually raised with Official Visitors tended to be about residents' living conditions for the BHRC's main role is to provide a home, albeit in a 'restrictive environment'.

* * * * *

The concept of 'community' is warmly persuasive and, as has been noted, is also ambiguous and vague in definitional scope. This chapter discussed the forms and functions of Canberra's mental health community through an historical examination of the development of its psychiatric services. Drawing on data generated by participant observation, I also considered the meanings, practices and roles attributed to the institutional and semi-institutional settings that make up the 'community' in which I undertook fieldwork. The design of Canberra's psychiatric services articulated a model of community that was diverse and flexible in order to be able to respond to a range of different *needs.*

I described how the landscapes of community may be experienced as enabling and facilitative, but only for those who have the capacity to access the spaces for rehabilitative care. Consumers who are not able to meet the expectations of this governmental regime tend to experience a trajectory of care that, alongside the arts of rehabilitation, also includes disciplinary techniques reminiscent of previous care regimes. While previous care regimes may have differentially valued the use of coercive and facilitative measures, the full repertoire of treatments continue to remain available and mobilised as a means of managing the fluctuating *needs* of the psychiatrically dis-ordered in the fragmented community settings of Canberra.

SECTION III

RELATIONSHIPS OF CARE

In the previous Section, I considered how the forms and functions of asylum and community reinforce the care regimes in which they are mobilised. I examined how the environmental settings of care ‘make up’ the possibilities for action of the inmate, the patient and the consumer.

In Section III, I explore how the dynamics of care are mobilised in the encounters between care providers and their recipients. Themes of shame and stigma permeate each of the chapters in this Section. Some of the continuities and discontinuities of meanings associated with ‘family’ and ‘community’ in each of the care regimes are observed. I consider the patterns of interaction between families and the asylum in the Herd Care era, the dynamics of the therapeutic relationship in the Therapeutic Community, and the guilt, grief and burden of care experienced by the carer. The subject of care emerges as an unpredictable and unruly, child-like figure or alternately as a degenerate, at times in need of protection and training and at other times in need of discipline and restraint.

8. Families and the asylum in the Herd Care era

Historians have examined the roles played by families in relatives' admissions and discharges from asylums.[79] Families were not only useful to asylum doctors, in assisting with diagnosis and approving a range of treatments. The asylum was also useful to the family, in providing respite from or final solutions for unmanageable people as well as for protecting the family's reputation. This chapter draws on the medical records of Kenmore Hospital and government documents for NSW asylum administration to examine the relations between families and the asylum during the Herd Care era. The roles of families in the pathways into and out of the asylum, their experiences of shame and stigma, are also explored.

Correspondence between the NSW Inspector-General and members of the public, and between the Medical Superintendent and the family, reveal a range of communications pertaining to the appropriate procedures for admission, the expected prognosis and progress of the inmate, and the forms of care and supervision each party believed the inmate should be subjected to. Representatives from the community regularly consulted the Inspector-General with regard to their concerns about the unacceptable behaviour or supposed incapacity of family members, neighbours or friends, and the processes and costs of admitting a person to a mental hospital. In April 1925, in response to a letter received by a person concerned about a young man described as 'epileptic, completely paralysed, and of impaired mentality', whose mother had died, and who they believed was not under 'proper care'; the Inspector-General advised that,

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[79] See, for example, Richard Adair et al, 'Migration, family structure and pauper lunacy in Victorian England: admissions to the Devon County Pauper Lunatic Asylum, 1845-1900' *Continuity and Change* 12(3) 1997; Cathy Coleborne, *'Madness' in the family: Insanity and institutions in the Australasian colonial world 1860s-1914* (forthcoming 2010); Mark Finnane, *Insanity and the Insane in Post-Famine Ireland*, London: Croom Helm, 1981 and 'Asylums, families and the state' *History Workshop Journal* 20 1985; Catharina Lis and Hugo Soly, *Disordered Lives. Eighteenth century families and their unruly relatives*, Cambridge: Polity Press, 1996; Patricia Prestwich 'Family Strategies and Medical Power: "Voluntary" Committal in a Parisian Asylum, 1876-1914' *Journal of Social History* 27(4) 1994; Nancy Tomes, *A generous confidence. Thomas Story Kirkbride and the art of asylum-keeping, 1840-1883*, Cambridge: Cambridge University Press, 1984; David Wright 'Getting out of the asylum: understanding the confinement of the insane in the nineteenth century' *Social History of Medicine* 10 (1), 1997.

> ... if the patient referred to can be certified by two medical men as being insane he can be admitted to one of the Mental Hospitals.
> The responsibility of getting him to the hospital rests with the friends, but in this case it would appear that the best course to adopt would be to ask the local Police, who are familiar with the procedure, to make the necessary arrangements for his admission and escort to a mental hospital. In this event the expense of certification and of travelling to the institution will be borne by the Police.

In the same year, a mother informed the Inspector-General that:

> our little daughter she is nine years of age. The Doctor's opinion is that she is of low mentality and shows dangerous signs. And Drs think it would be far better for the child to be put in Newcastle Hospital. We have tried other Hospitals but they have all recommended Newcastle M H.

The Inspector-General advised that:

> ... if you are desirous of placing her in the Newcastle Hospital two courses are open to you, and determination as to which one to follow is a matter of expense. If you are in a position to pay for two medical certificates and yourself take the child to the Hospital, you should fill in the attached form and the child will be admitted on your presenting same to the Medical Superintendent. If, however, you are not in a position to meet this expense you should communicate with the local Office of Police who will take the necessary steps to obtain an order for the child's admission and for payment of the expense of escort to hospital.

Parents could also use the laws pertaining to 'voluntary' admissions as a means of having their children admitted to the asylum. In 1925, in response to a letter of enquiry, the Inspector-General stated that:

> A medical certificate is not necessary to obtain admission as a voluntary patient. The person desiring admittance attends at the Hospital and signs a request for admission, in which he agrees to abide by the rules laid down by the Medical Superintendent.

Sixteen-year-old Tim Hocking's father organised for his voluntary admission by writing to the Medical Superintendent of Kenmore as follows: 'I have decided to ask you herewith to accept my son into your Institution as a patient, for treatment for so long as you think necessary.' Hocking had been charged with indecent exposure and was taken to Kenmore for examination and confinement.[80]

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[80] Voluntary admissions to Kenmore are discussed in greater detail in Chapter 12.

Figure 8.1. Families' Involvement in Committals and Discharges

Of 69 Canberra patient files, 10 were missing. Of the remaining 59, 11 inmates died during their stay, two escaped, one was deported, and four were transferred to other asylums. The case notes and admission registers of Kenmore do not corroborate the claims of asylum admissions of up to 80% due to family intervention (Wright 1997:142). This may be attributed to aspects of Canberra's demography and to Kenmore's incomplete and inconsistently recorded case notes. Of the 59 files of former Canberra patients, however, more than half (34) have evidence of family contact with the asylum, either during inmates' admission pathways, in signing treatment authorisation forms, and/or in general correspondence with the Medical Superintendent.

From the above figures, I could conclude that - at least for those inmates with files - 41 were released back into the community. Of these, 19 were released On Leave, into the care of either family (17) or friend (2). Therefore, almost 50% of known releases were released into the care of the family.

The extent of family involvement in patient discharges could have been higher in a different demographic, for example, in a town with more extensive family support networks. The average Canberra resident, as discussed elsewhere, did not have support networks beyond the nuclear family formation. In the case of overseas immigrants, the majority of their families lived overseas. Migrants made up approximately 30% of Canberra inmates, and male migrants overwhelmingly outnumbered females, 86:14. The typical Canberra inmate was a single male, reflective of the frontier town's demography in which men outnumbered women. These men did not always have a family to turn to. Their pathways to asylum care were usually for alcoholism and/or social issues, and they tended to be released after several days or weeks. In the case of these men, family involvement was not crucial to their discharge.

Correspondence between the Medical Superintendent and the inmates' families reveal the roles they played in processing applications for leave from the asylum. Families could apply to take inmates on temporary 'outings'. With the asylum's support, they could also expedite inmates' probationary releases by signing a form guaranteeing 'to make due provision for (their) proper care and safekeeping and to bring (them) to the Hospital for examination on (a specified date) or to send a Medical Certificate instead.' If the probationer passed the medical examination, they would be formally discharged while On Leave.

Inmates without family could find their stay extended. For example, in the case of Frank Barbaro, a note on his file reads: 'Cannot let him go until someone will take responsibility for him.' At times, inmates' friends could step in and take on the responsibilities of family. Barbaro's family lived overseas and he was advised to seek formal support from friends living in Canberra. Approval was given for Barbaro's conditional release into the care of friends after 16-months' confinement at Kenmore.

If the asylum doctors deemed it appropriate, friends (and family) were also invited to request changes to the legal category and status under which inmates had been admitted. For example, in a letter from the Medical Superintendent to a patient's friend:

> He was very upset after a visit yesterday and ran away from the Hospital. He is at the present time a voluntary patient. He is not a suitable patient for voluntary treatment and should be certified. I would be glad if you would sign the enclosed form requesting his admission to the Reception House, Kenmore.

Legal recognition of inmates' diminished capacities for autonomy authorised the asylum, and encouraged the family, to act as overseers of the management of their lives.[81] The Medical Superintendent would, upon request, provide the family with progress reports regarding the mental and physical condition and general welfare of their relative. At times, communications between the Medical Superintendent and the family continued after the release of inmates. Families sought advice regarding any concerns about family members released into their care and also furnished progress reports to the asylum. After Elizabeth Gallagher's conditional release, her husband notified Kenmore that his wife was 'remarkably well and youthful looking'. 'She has been in charge of a house here for two weeks and manages very efficiently.' Kenmore advised Mr Gallagher as follows: 'I trust that no heavy strain or responsibility will be put on her for some time lest it should be too much for her.'

Authority over the daily lives of all inmates was, of course, vested in the Medical Superintendent. His interactions with family members were conducted in formal, prescribed ways. Letters were the main form of communication. Throughout the years, the voice of the Medical Superintendent emerges as a benevolent and paternalistic expert. He could, at his discretion, invoke medical knowledge and managerial priorities above families' wishes. For example, a 58 year old patient was discharged three weeks after admission despite the plea from his 85 year old sister not to release him because she could not look after him, and because he had caused her nothing but 'trouble and expense'. The Medical Superintendent replied: 'We are going to discharge him next Monday. He is very much better mentally and physically.'

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[81] For example, on the grounds of insanity, inmates could have their children placed up for adoption, they could be divorced, and they could lose voting rights. These decisions were made at the discretion of asylum doctors.

Families sought advice from the Medical Superintendent regarding the suitability of inmates' discharge. Victoria Brewer's parents were advised against her discharge because she was, according to the Medical Superintendent:

> rather erratic and ... irresponsible and generally pathetic and untidy, and foolish, irresponsible and self-absorbed in delusions of an erratic character. Her supervision at home would be likely to cause considerable embarrassment at times ...

In the case of Judith Kirkpatrick, her father was advised that:

> your daughter has been better behaved and also happier in herself than she has been for some time. However, I don't think that she would be well enough to obtain any employment even with supervision. She talks in a very foolish fashion about committing suicide and the various crimes she will commit if she leaves Kenmore. I am sure that even should she never put any of these plans into effect her conversation along these lines would nevertheless be most disturbing to any potential employer.

During admission procedures, families could be utilised as sources of knowledge. The degree to which asylum doctors relied on families' accounts closely correlated with the family's circumstances and social location and, in some cases, family members could also come under psychiatric and moral scrutiny, thus inadvertently providing clues or aids to deciphering the psychiatric condition of the prospective asylum resident. Hocking's family, including his father who had made application for Hocking's voluntary admission, are described in his case notes as follows:

> It is a difficult matter to obtain any accurate and ordered family history relative to Hocking. The father is an ex-pugilist ... with a reputation of being able to withstand any and all punishment. Three brothers still alive and all pugilists and apparently all able to assimilate untold punishment. The boy's father is mentally dull and could be described as "Punch drunk". ... <u>He states he "drank a good deal and knocked about with women a lot". He denies syphilis and VD generally but not convincingly.</u> (The underlined sentences refer to the background history of the father rather than the patient.)

Where possible, families were also used to give permission, on behalf of the inmate, for treatment procedures such as, for example, Electro-Convulsive Therapy. Consent was routinely requested from the family, through the use of the following form:

> ECT entails a slight risk of injury to the patient and as is the case of a General Anaesthetic complications very occasionally arise during treatment. The consent of the relative is therefore always obtained and I shall be grateful if you will sign the following and return it to me as soon as possible.
>
> I wish .... to have Electric Shock Therapy and I absolve the Hospital Authorities from any responsibility for any complication that might arise from the treatment.
>
> Signed ....
> Relationship to Patient ....
> Date ....[82]

There is no evidence on inmates' files of families declining to give their permission for treatment.

Themes of shame and stigma[83]

Case notes of Canberra patients suggest that, at times, families were obliged to comply with moral conventions as a consequence of social control mechanisms exercised by the neighbourhoods and communities in which they resided. On these occasions, the asylum provided a solution for removing embarrassing people from the family home.[84] Margaret Black was brought to Kenmore in the 1930s by her husband from what appears to have been a case of physical and psychological exhaustion. Black was a full-time mother. She was brought to Kenmore after turning out 'all her friends out of the house last Wednesday' and for stating that she 'heard God getting shot'. Upon her arrival at Kenmore, Black was described as 'abusive, quarrelsome, destructive'. While she seemed to fit into a middle-class milieu – she enjoyed participating in 'tennis, golfing, and dancing' – she was also a migrant of Scottish background who had arrived in the Nation's Capital without family support. Her case notes suggest that she was worn out from her domestic responsibilities: (h)er two children have just recovered from sickness and the patient has been looking after them'. After three months in the Female Noisy and Violent Ward, with the regular treatments of seclusion and camisole, Black was described as 'more settled and rational'. She was subsequently discharged into her husband's care.

In most cases, Canberra families regarded asylum care as a temporary solution for a desperate situation. Letters from some family members suggest that

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[82] Standard form letter on the files of (some of the) Kenmore inmates who received ECT.

[83] A common theme in the writings of Geoffrey Reaume (2000) and Charlotte Mackenzie (1992).

[84] Mackenzie writes '(i)f anticipated shame and embarrassment was one reason why patients and their families might resist or postpone certification, ... these emotions could also make a family eager to remove a patient from their family circle, in order to conceal their disorder' (1992:102).

they were anxious for their unwell relatives to return to the family unit as soon as possible. Husbands were concerned that their wives be able to resume their domestic responsibilities within the family home, and women and children were financially affected by the removal of the family breadwinner.[85]

Alongside families' practical concerns regarding the economic and social viability of their households was their awareness of community perceptions of the asylum as a holding environment. The gossip that may have led to family members being committed to Kenmore did not necessarily cease after their confinement. Canberra's residents might not want to accept unruly people within their neighbourhoods but they were also aware of the powers vested in the asylum, powers which could be abused by families who wished to dispose of unwanted relatives.

Community suspicions regarding families' intentions were documented on William Faulkner's case notes. Admitted in the 1940s, Faulkner was a returned soldier diagnosed with a depressive condition. His progress notes read as follows:

> Visited by wife. Mrs [Faulkner] is very disappointed as her husband showed no pleasure or interest in seeing his visitors, did not appear interested in going home and did not bother to enquire regarding the (well-being) of his 6 year old son. The patient seemed anxious to be rid of his visitors and fidgeted during the visit.
>
> Continues to be usefully employed in Male Reception. Professes to be quite contented and happy here with no intention of leaving. Cheerful and friendly in manner, but not anxious to talk about circumstances leading to his admission and when relations with his family discussed tends to become ill at ease.

In a letter from the Medical Superintendent to Mrs Faulkner, her husband's progress is described as follows:

> He is cheerful, active and usefully occupied. However, he has not regained confidence in himself and so far cannot bring himself to face conditions in the community.

In a letter to the Medical Superintendent, Faulkner's wife wrote that members of Canberra's community were accusing her of not signing papers to allow his release, and that she was keeping him at Kenmore because she wanted him to remain in institutional confinement. Kenmore provided written confirmation for Mrs Faulkner that her husband 'was admitted as a voluntary patient. He is remaining here of his own free will. He does not appear to have any desire to

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[85] This finding is corroborated in the writings of Prestwich (1994). David Wright suggests that the decision to commit or to avoid confinement was mediated by the economic and household roles of the unwell family member (Wright 1997:151).

leave the institution.' Faulkner died in Kenmore after 13 years of asylum care as a voluntary patient.

At times, community suspicions about unscrupulous families were justified. Anecdotal evidence from group interviews with former psychiatric nurses suggests that Kenmore was at times used as a repository for disposable wives and immoral daughters. Evidence from the case notes suggests it was also a potential repository for difficult mothers-in-law. Notes on Anne Parkinson's file read as follows:

> Mrs (Parkinson) is very troublesome and he (the son-in-law) stated that they could not put up with her any longer. It appears from a note supplied to ... (the son-in-law) by a medical practitioner at Canberra, and from information given to me by ... (the son-in-law)... that Mrs (Parkinson) might be considered to be insane.

Parkinson was admitted to Kenmore for observation and possible certification. She was discharged after several days though, because the charge of insanity could not be substantiated.

Elizabeth Gallagher believed she was no longer wanted by her husband and that she had been taken to the asylum so that he could have her declared insane and then subsequently divorce her. Her husband repeatedly denied these claims and in one letter to the Medical Superintendent, he wrote: 'I am prepared to go to any lengths to correct that error and to make her want to come back home in peace.' In another letter, he wrote:

> Very distressing seeing my wife so miserable today and heart-breaking to hear her screams when she was pulled away from me and locked up. She complained to me mostly of loneliness, the confinement of the wards. … PS: I noted that [Elizabeth's] hands were shaking all the time she was with me. I am unable to resist her appeal to take her home. (emphasis in original)

During her stay at Kenmore (late 1930s), Gallagher was subjected to 23 Cardiazol (intravenous pentylenetetrazol) injections; and Weir Mitchell Treatment consisting of six weeks seclusion while under restraint in a straight jacket. In a letter to her husband, the Medical Superintendent describes her response to the treatments as follows:

> She has been kept isolated for the past three weeks and it has been noticed that she is very quiet until someone goes to see her when she becomes noisy and tearful. She is always at her worst, when one of the doctors, especially myself, goes to see her. It is our definite opinion that whilst some physical condition is at the root of her trouble, most of her acute mental symptoms are hysterical. The condition has now gone on for two years. With isolation she is looking much better and is eating better.

After 11 months, Gallagher was released into the care of her husband. In her file I found a letter she had written to her husband (Plate 11). Asylum staff had decided that its contents were unsuitable for posting, and the letter remained enclosed in an envelope, attached to her case notes. The letter is a rare find of inmate voice.

Plate 11. Letter from 'Elizabeth Gallagher' to her husband[86]

> Man Man I am suffering the tortures of hell. I am British and a free agent you are holding and having held my body in torture. ... agony of mind and body ... you are free and well with no one attacking you. ... A strange doctor cross-questioned me today on most personal matters. ... My body is my own. You have finished with it but am I to be cast to a dark dungeon thirsty cold and hungry ... You are cooperating with these people to keep me in abject misery. ... It is slow murder. You want your freedom. Let it be arranged in an honourable way. I have been reduced to a state of suffering unnecessarily. Give me ease air and water cleanliness I am human not an animal. If I cry in pain I have air shut away from me. ... You have signed my body away to torture pretending to Canberra people to the contrary. ... Remove me on Saturday without fail and away from continual molestation. Every minute is terrible and I get no sleep. Heed me help me in God's name. These people have no right to my poor emaciated body. Remove me in God's name. Murder me rather literally as now you are metaphorically dismembering my body.

The dynamics of care

While institutional care could provide a respite for the family and, in some cases, the inmate, the files of Canberrans confined in Kenmore suggest that it was mainly used as a solution only after families' caring resources had been depleted.[87] For some, Kenmore represented a final solution for those in need of

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[86] Emphases are in original, and the comment about the 'strange doctors' is a reference to questions about her sexual history, which she refused to answer.

[87] Similarly, Mackenzie found that persons who 'had become unmanageable at home because of their tendency to wander away from home, or cause disturbances locally' could find themselves admitted into institutional care at Ticehurst (Mackenzie 1992:103).

nursing care. Thomas Mayne spent his final weeks in Kenmore. The 80-year-old was brought in by his daughter who was described as ‘worn out by her efforts in looking after him’. Edward Walton died at Kenmore, twelve years after his admission. Walton had been arrested and charged with lighting grass fires and carrying a loaded pistol. He had also developed a reputation in the community as a ‘nuisance ... stopping motor vehicles for a lift, etc., and abusing persons who do not assist him on demand’. Although the 82-year-old lived with his son, an asylum doctor was not convinced Walton was receiving a proper standard of care: ‘he was in a filthy condition. In my opinion the son is not a fit and proper person to care for him even if his mental condition was such that he could be safely released’.

Ronald Jones was admitted to Kenmore aged 17 years at the request of his father. Jones was described as follows:

> Lies in bed with a vacant expression then suddenly becomes violent. Has to be forcibly restrained. Cannot answer questions. Masturbates in front of parents. ... Gross retardation.

Jones’ father regularly corresponded with the Medical Superintendent, expressing his concern at his son’s weight loss and psychological deterioration. Ronald Jones did not respond positively to the care he received in the asylum and he died at Kenmore aged 20 years. Ruby Nelson was admitted to Kenmore for mental deficiency and epilepsy. Nelson was aged 19 years at the time of her admission. Her mother had died and her father could not look after her. Described as short, with ‘mongoloid eyes, open mouth, vacuous expression’, Nelson could not feed herself, was incontinent and could not ‘indicate wants or make any intelligible sounds’.

The asylum provided protection for some families by forcibly removing violent people from the home. David White’s case notes suggest that the main reasons his wife had him committed related to his violent behaviour and extra-marital affairs rather than a psychiatric condition.[88] White’s wife had tried on

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[88] Similarly, in their comparative case study of private confinements in 18th century Antwerp and Bruges, Lis and Soly note that violence and alcohol were the main reasons for wives requesting confinement of their husbands (Lis and Soly 1996:92). Prestwich writes that domestic violence and alcoholism were underlying reasons for wives seeking asylum care for their husbands in late nineteenth and early twentieth-century Paris (Prestwich 1994:805). Reaume describes several cases of wives imploring the Medical Superintendent of the Toronto Hospital for the Insane to keep their husbands locked up out of fear of the violence they would be subjected to by a ‘brutish spouse’ if released back into the community (Reaume 2000:201-203). Mackenzie notes that ‘(v)iolence to people or property, and threats or attempts of suicide, were amongst the most common reasons given for certification’ at Ticehurst (Mackenzie, 1992:103).

several occasions to have him committed because she was concerned about her own safety. She stated that White had assaulted her in the past. In her letter to the Medical Superintendent she notes that,

> (i)t seems very dreadful to me that about nine doctors have examined [David] within the last nine months and all are of the same opinion regarding him but I must wait until he does some grievous bodily harm to myself or some other person before anything can be done to have him put under treatment.

Finally, Mrs White found a doctor willing to recommend that her husband ‘should be remanded in Reception House for observation and investigation of his mental condition’. White was brought to Kenmore under police escort.

White’s case notes reveal regular correspondence between his wife and the Medical Superintendent, relating to his unruly behaviour as well as concerns for his well-being. Upon his admission, White expressed the view that he was sane and that his wife had conspired to have him committed into asylum care. Kenmore was initially not convinced of White’s insanity. The Medical Superintendent wrote to Mrs White: ‘he is a difficult case because there is no doubt an element of truth underlying his delusions (of conspiracy)’; and in a subsequent letter: (c)ould you find time to write me a full account of [David’s] illness from the very start. How long have you thought him insane and what made you think so and what was it made other people think him insane?’ Mrs White’s response suggests that her husband was guilty of immoral and bad rather than mad behaviour. In addition to complaining about his violent behaviour, she described her husband as a ‘sexual maniac’ and an adulterer. Despite Kenmore’s initial bafflement with White’s mental condition, he was confined in the asylum for eight months until one night, after attending a Picture Show, he managed to effect his escape. He was never recaptured.

The asylum also offered families institutional control on those occasions when the moral authority of the family patriarch was inadequate for managing unruly relatives. Kenmore provided Judith Kirkpatrick with a moral guardianship described in her case notes as ‘hospital control’. Kirkpatrick’s father had difficulties in keeping his daughter in the family home. Kirkpatrick was admitted to Kenmore aged 13 and was eventually discharged from asylum care aged 26. Despite being described as having a ‘history of irrational impetuous conduct’, Kirkpatrick was given probationary and temporary releases into the care of her father on numerous occasions. She was at times returned to Kenmore by her father because he had difficulties in managing her behaviour: ‘she was uncontrollable and “too much worry”’.

At times, families could continue to exert limited forms of control over Kenmore’s inmates. This was to some degree dependent on the families’ educational background, their social standing in the community and the relations they had established with the Medical Superintendent. Edith Hunter’s father, a military officer, requested that no correspondence be permitted between his adult daughter and two people who he believed had a ‘subversive’ influence on her. The father also insisted that his daughter be forbidden to smoke. When his daughter requested permission to marry a non-English speaking migrant, the Medical Superintendent responded, ‘I could not consider to allow you to leave this institution for the purpose of being married without first discussing the matter with your people and the Inspector General.’ Permission was never granted.

Family influence could affect the administration of asylum transfers. Subject to bed availability, inmates could be transferred to other asylums at their families’ request. The reasons for making such a request were generally therapeutic, to facilitate the visits of relatives and friends. Nora Shannon was initially committed to Parramatta Hospital, Sydney at the request of her husband. Shannon was in her late twenties and a mother of several children. Her diagnosis was Acute Mania, its onset attributed to ‘Domestic troubles’. After one year, she was transferred to Kenmore at her husband’s request, to enable him to visit her more regularly. Shannon’s file contains many letters, both from her mother and her husband, requesting information on her condition. Eighteen months after her arrival, Shannon’s mother expressed her preference for Shannon to be transferred back to Parramatta on the grounds that she ‘would lose those delusions quicker if she were among her own people’. For reasons not articulated on Shannon’s case notes, her husband consented to this transfer. After two years, Shannon was transferred back to Parramatta, despite some concerns expressed on her Record of Progress notes, that she might have found her mother’s visits unsettling. There is no evidence of Shannon being consulted about her views regarding the transfers between Parramatta and Kenmore. Her movements between the two asylums were directly as a consequence of the interventions of her husband and her mother.

His family’s social standing in the community influenced the kind of institutional care Andrew Williams received during his confinement at Kenmore.

Williams was educated in a private boarding school and came from a wealthy family. He was granted privileges within the asylum in a relatively short time: 'since being here he has been a privileged patient working in the store'. Williams was sent to Kenmore as a means of avoiding a prison sentence for sexually assaulting young boys, described as 'interfering with boys'. In a letter to the Williams family solicitors, the Medical Superintendent wrote:

> he is a moral imbecile, with no idea of right or wrong ... he is a danger to the community at large ... I would be glad to know ... if his people wish him to be certified as insane, or if they wish him to stand his trial and for me to give evidence of his mental condition.

Asylum doctors diagnosed him with Congenital Mental Deficiency (Moral) on the grounds that:

> (h)e has no interest in girls at all. I consider he is insane on this matter of abnormal sexual desires and I do not think he is capable of controlling his own desires in this direction.

Williams' certification and confinement in an asylum provided a way for his family to avoid a public trial and media attention. This strategy was not isolated to Kenmore. Drawing on her study of Seacliff Asylum 1890-1920, Brookes writes that 'sexual vice' was an admissions pathway that 'circumvented the anguish of airing family scandal in court' (Brookes 1992:134).

Much to his brother's concern, Williams abused his privileges at Kenmore by engaging in correspondence with twin brothers with whom he had become fixated and whose education he had been paying for. In a letter to the Medical Superintendent, referred to in earlier correspondence as 'our best and wisest friend', Williams' brother suggests that the asylum should consider using some disciplinary measures against Andrew:

> In spite of my warning to [Andrew] that further association with those boys would be to their detriment, I find that he has been in communication with them. The letters have probably not gone through your hands. [Andrew] has had considerable latitude there, for which we thank you. This correspondence has been an abuse of privilege ... I commandeered the letters ... told the boys that the best thing they could do ... would be to cool the relationship. This ... is ... written ... for your information, perhaps to be utilised in a talk or two with [Andrew]. [89]

It is not clear whether Williams' brother was more incensed by his abuse of privileges at Kenmore, by his indulgence of his homosexuality, or by his financial

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[89] It was standard asylum procedure to read all correspondence and, if necessary, censor letters written by inmates. Writings by inmates were viewed as objective proof of their insanity or as markers of their subsequent return to sanity. Williams' privileged position in the store gave him opportunities to send letters that had not been subject to asylum censorship and control.

support of two men unrelated to the Williams family. The case notes do not reveal if Kenmore took the brother's advice that Williams face formal reprisal.

Williams never stood trial and was released into the care of family and private psychiatry after a six months' stay in Kenmore.

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This chapter illustrated the different ways in which Canberra families expressed interest and concern about the well-being of family members, and their role in committals to and discharges from Kenmore. Themes of shame and stigma were analysed. There is no doubt that in addition to the embarrassment of relatives' inappropriate behaviour, the stigma of madness symbolised by the asylum geography contributed to feelings of shame in having a relative confined in such an institution. In the next chapter, the concept of family is sustained by examining the roles and responsibilities of nurses in both the Herd Care and the Therapeutic Community eras, in the stigmatised family formation of the asylum. Key to understanding the meanings of family that permeated asylum culture is through the analysis of nursing roles and responsibilities, for it was the nurse who acted *in loco parentis* over his or her charge.

9. From ‘keeper’ to ‘key therapeutic figure’[90]

> *They looked on us as their family, a lot of them, because they had no one else, and a lot of us were away from home too. ... it wasn’t uncommon for some of us to take them to our home ... I mean, my kids were very familiar with this place.* (Linda)

Linda is describing the kinds of interactions available to nurses and asylum residents in the Therapeutic Community of the asylum. This care regime was contrasted by nurses with the Herd Care era, when a more distanced and authoritarian approach was emphasised. Despite these differences, throughout most of its history Kenmore’s organisational culture reflected family values, and a key premise of this chapter is that nursing practice both reflected and was creative of family formations in the asylum during both care regimes.

This chapter examines some of the dynamics between nurses and their charges in the Herd Care and Therapeutic Community eras. Aspects of the therapeutic relationship, the acts of care mobilised by the psychiatric nurse in which he or she actively seeks to ‘personally influence the mental health status of patients’ (Reynolds and Cormick 1990:6), are described. I argue that the therapeutic relationship was mobilised in each care regime through the metaphor of family. Nurses were engaged in parental roles of nurturer, educator, disciplinarian and trainer over residents lacking in capacity for autonomy; but these roles were modified in accordance with the norms underpinning each care approach. I explore how the structures of working lives were creative of close-knit ties that encouraged the interweaving of public and private lives. The resultant camaraderie between nurses was reinforced by the shared experience of working in a stigmatised institution. In this family formation, it was also possible for some residents to cross the boundaries separating nurses’ public and private lives. Although there were overlaps between each care regime, in general, Herd Care may be imagined as an authoritarian family structure, while the arts of Therapeutic Community promoted the values of a permissive family formation.

The Therapeutic Relationship

Digby writes that ‘the key to moral treatment lay in the quality of personal relationships between staff and patients’. Attendants working at the Retreat were expected to exhibit ‘qualities of integrity, humility and selflessness’ (Digby

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[90] Lloyd 1976:38.

1985:56-57). The importance of personal character continues to be emphasised two hundred years after the Retreat opened its doors:

> I think people who are psychiatric nurses have a very important job to do. However, what's equally important and precious is the presence of the person or the human being doing that job. It's not just the job itself, it's the person inside.[91]

O'Brien suggests that the therapeutic relationship emerged in the mid twentieth-century as a body of knowledge, to distinguish asylum practice from a custodial era (O'Brien 2001:135). Writing on the therapeutic relationship, Reynolds and Cormick imply that a good nurse is someone with an anthropological sensibility. They advocate nursing qualities such as empathy and the quest for understanding of the cultural Other on their own terms:

> Empathy, the ability to put yourself in another person's place, has been said to be the most important facilitator of the therapeutic (helping) relationship. Clearly, there is little point in knowing that the client feels down or tense unless one understands the personal meaning that those terms have for the individual. ... In order to understand accurately it is also necessary to study the client's culture and social system by moving out of the institutional frame of reference into the family and world in which the client lives. (Reynolds and Cormick 1990:11)

The confining and medicalising forms and functions of the 'institutional frame of reference' such as the asylum and the psychiatric ward of the general hospital have, however, historically constrained and challenged the nurse's ability to adopt an anthropological sensibility or, as Reynolds and Cormick describe it, a 'dynamically oriented investigative approach' (Reynolds and Cormick 1990:11). Within the confines of these strictly regulated institutional cultures the goal of most nursing endeavours is the conformity of the patient, and therein lies the tension of the therapeutic relationship. This tension is not, I would suggest, unique to twentieth-century nursing but is loosely connected to generic managerial concerns in large and complex organisational forms:

> Much of the contemporary interpersonal competence seems to entail success in getting patients to conform to roles they are supposed to play in the social system of the hospital, so that the system will work smoothly. (Jourard 1964, cited in Reynolds and Cormick 1990:8)

Thus, to guide patients into conformity, nurses are expected to take on a parental persona, involving the 'bathing, feeding, dressing, toileting, warning, disciplining' of patients; 'medicating and monitoring the effects of others' treatment'; and acting as 'environmental safety' agents, including the 'prevention of self-harm, wandering, hostility, starvation' (Reynolds and Cormick 1990:8).

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[91] A conversation between service users in 2001 (Roper 2003:60).

In the interests of conforming to rules and promoting safety, the therapeutic relationship may involve the mobilisation of coercive techniques in response to violations of the moral order (O'Brien 2000:130). If the use of coercion may be viewed as a form of 'doing good', it also assumes a knowledge of what is 'good' for the client. The use of coercion by nurses is justified by reference to a duty of care and the claim that 'clients have limited autonomy' (O'Brien and Golding 2003:169; Lützen 1998:106). While this paternalistic response may restrict clients' freedom of choice, it is viewed as a protective mechanism for the client's benefit and safety (Reynolds and Cormick 1990:6). The use of coercion to manage client choice and freedom may include subtle forms such as '"helping", persuading, deciding for, encouraging, trading-off, manipulating' and 'half-truths, under-disclosure, restricting possible choices ... false information' (Reynolds and Cormick 1990:6). Overt forms of coercion include '"threatening", "physically restraining", "restraining by giving injections by force", "mechanically restraining" and "locking doors"' (Reynolds and Cormick 1990:6).

The arts of surveillance are integral to all activities of the therapeutic relationship, including those undertaken in group settings.[92] Nurses make decisions that affect clients' well-being based on the techniques of observation, evaluation and assessment: 'Every time you see a client you're making an assessment .... Even if you don't actually ask questions you're assessing somebody'.[93] Assessments, however, are not only instruments of science. They also rely on information obtained through a process of ambiguous and messy social intercourse. In a qualitative study of ten British psychiatric nurses, Lützen discovered that assessments resulting in 'doing good' were more likely to be mobilised by 'practical experience, feelings and intuition' (Lützen 1998:107). This suggests that the decision to use coercive measures is in part based on nurses' subjective feelings and intuition. Lützen asks that if coercion may be justified, in 'whose judgment do we trust, and why?' (Lützen 1998:107). More broadly, her writings also remind us of Scull's observation, of the 'tensions between ... the imposition of moral discipline and the development of self-government and self-control' that are embedded within moral treatment (Scull 1993:14) and, I propose, within all arts of care.

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[92] Latham notes the opportunities offered by group therapy to monitor individual patient participation and then record observations on 'any positive or negative changes in patients' behaviour' (Latham 1981:53).

[93] A nurse's perception of practice, cited in O'Brien 1999:158.

If, as Lützen suggests, a therapeutic relationship is dependent upon building trust with the client, then use of coercion and surveillance may at times strain the viability of this relationship (Lützen 1998:5). These tensions become exacerbated when nurses' clients are involuntary detained and treated, creating for the client 'an experience of intrusion, invasion and coercion' (O'Brien 1999:159).

The threat of coercion remains the underlying cause of distrust and conflict between the care provider and the recipient of care (O'Brien 1999:159). It is not surprising, then, that clients may distrust the precepts of the therapeutic relationship. Sam is a former patient of Kenmore and currently, a consumer of Canberra's mental health services. Not much, according to him, has changed in the mental health system. The seclusion room – an *unnecessary and cruel* device – still exists. And *a nurse is still a nurse* – someone who *can still inject you all the same*.

In the next section I examine how the tensions of the therapeutic relationship were negotiated in a stigmatised geography of belonging and dysfunction.

The stigmatised family formation of asylum: place of belonging and dysfunction

While the figure of the Medical Superintendent has generally been represented as the key to understanding the patriarchal order of the asylum (Gittins 1998:59; Scull 1979:103), I propose that it was the structures of nurses' working lives, of living on Kenmore's grounds and training through an asylum-based scheme, that imbued the institution with the authenticity of a family formation. While at times the therapeutic relationships between nurses and their charges resembled those of a dysfunctional family, at other times the asylum family was a place of belonging for both care providers and the recipients of care. This section illustrates how meanings of family as site of belonging and dysfunction evolved in the daily routines of nurses' working lives, overlapping both care eras.

To varying degrees, Kenmore stigmatised all who came within its orbit. In the previous chapter I described the shame experienced by families as a consequence of their association with the asylum. Their affiliation with the asylum also shamed Kenmore's female nurses in a form that has been described by Goffman as 'courtesy stigma' (Goffman 1963). Through their work, nurses normalised a form of deviance and thereby contravened a societal tabu in their daily interactions with Kenmore's residents. Nurses familiarised themselves with the various permutations of cultural otherness. As a consequence asylum residents could, to varying degrees, receive an acceptance from nurses that they did not generally experience in the community. In common with nursing colleagues in palliative care, asylum-based nurses normalised a cultural transgression and as a consequence became stigmatised courtesy of their association with residents.[94] Based on interviews I conducted with former nurses, it appears that females were more likely to be affected by courtesy stigma than males.

Most of the female nurses I spoke to made reference to the negative effect of telling people they worked at Kenmore:

> *And, this family friend of ours ... rang me up and she was so upset that I would even think about going into psychiatric nursing. ... good girls did not go psych nursing ... and that's how the community thought of us. So fellows, if you met any at dances in town, you never told them you worked at Kenmore, in the first instance, because you were easy prey, ... I can remember the first boyfriend I had here, and when he told his mother that he was going out with a nurse from Kenmore she was horrified: 'don't bring her to my house'. ... that was the reaction ... psych nurses were always second-class citizens ...* (Julie, who commenced working in Kenmore in the 1960s)

Kenmore nurses had the reputation of being *loose*, easy pickings.[95] Although general hospital nurses have had to contend with female stereotypes of the seductress and the dominatrix and conversely, maternal and angelic representations of healers, asylum nurses were doubly tainted by their daily exposure to the mad. In contrast, male nurses were adamant that they did not experience stigma or the need to cover up where they worked. The different experiences of male and female nurses in relation to community responses toward their work may be explained by examining how gender is mediated by the Western binary oppositions of rationality vs. irrationality and culture vs. nature.

Some historians have considered the different social and political contexts for depicting females close to nature with a biology that predisposes them to

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[94] McNamara writes that, in contradiction to the mystique of death that permeates Western society, palliative care nurses normalise death and dying in the course of their daily working lives (McNamara 2001:117).

[95] Similarly, Prebble writes that psychiatric nursing in New Zealand was not viewed as respectable work for women (Prebble 2005). In contrast, Dooley locates the connotation of female nurses as *loose* women within inter-generational, educational and class differences between psychiatric nurses. One of the nurses who trained at Brandon in the 1930s is quoted: 'Earlier nurses in mental hospitals had a reputation of being low class and fast women or something ... because they weren't educated, but they really were a poorer type .... We were very respectable, but apparently years before they had fast women, which meant that they drank and smoked. But none of our gang drank and smoked.' (Dooley 2004:245)

irrationality and, at certain times of their life-cycle, madness.[96] Female nurses' work within the asylum, in their daily negotiation of moral and physical dangers, was not becoming of middle-class femininity. A consequence, then, of their closely intertwined relations with Kenmore's residents, was the belief that female nurses were vulnerable to going native.

Male nurses, as embodiments of rationality and culture, were not viewed as susceptible to madness. Their gendered identity was not compromised by their work in the asylum. Their masculinity, symbolised by their physical size and strength, may have even been reinforced through their work as role models for and supervisors of the insane. Monk locates the authority and status of the male attendant in his position as 'man of reason' (Monk 2001:7). This position not only legitimised his presence within the asylum but it may also have gained him ready acceptance within his community.

Community perceptions of male and female nurses may also have been exacerbated by gendered recruitment regulations, which were practiced at least until the 1960s:

> *Most of the male staff were married – they were older. You see, we could start at 16 and 10 months but they had to be 19 to start here. By the time most men started here they had a trade, and a lot of them were married.* (Linda)

The image of a young, single, female nurse is suggestive of vulnerability and the possibility of unbounded sexuality, whereas male nurses' age and marital status tended to reinforce their respectability.[97] As a consequence of her biology and social status, it is not surprising that it was the female nurse who represented a potential polluting threat to the moral fabric of the community.

The stigmatising effects of madness and madhouses fostered a sense of solidarity amongst nursing staff, reinforced by the asylum's physical isolation

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[96] See, for example, Catherine Coleborne, *Reading madness: bodily difference and the female lunatic patient in the history of the asylum in colonial Victoria*, 1848-1888, unpublished doctoral thesis, La Trobe University, 1997; Stephen Garton, *Medicine and Madness: A social history of insanity in New South Wales, 1880-1940,* 1988; Mark S Micale, Hysteria Male/Hysteria Female: Reflections on Comparative Gender Construction in Nineteenth-Century France and Britain, in Marina Benjamin (ed.) *Science and Sensibility. Gender and Scientific Enquiry.* 1991; Wendy Mitchinson, Gender and Insanity as Characteristics of the Insane: A Nineteenth-Century Case, in *Canadian Bulletin of Medical History*, Vol. 4, 1987; Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980*, 1987.

[97] Another example of the divide between the different status positions of male and female nurses is unintentionally provided by the Director of State Psychiatric Services, in his reference to the recruitment of 'girls and men' for nursing positions in NSW asylums (1963:11).

from Goulburn, and by nurses' long work hours.[98] Staff formed a close-knit form of sociality that was culturally distinct from the surrounding community:

> *This was like a little village of its own, because … we had our own rules and we had the pictures and the canteen and … the farm and our own laundry … we were real self-sufficient.* (Brenda)

Apart from its exchange of dairy products for bread with Goulburn Gaol, Kenmore functioned as a self-sufficient village until the 1940s. A culture of separateness from the community and a sense of belonging within the family asylum fostered a particular kind of 'closed community'. At times, the family-like setting benefited both nurses and residents who lived away from their families. Unlike Goffman's total institution,[99] the daily lives of nurses and their charges were 'closely intertwined'.

The intertwined nature of their interactions was at times further complexified by the inclusion of nurses' relatives in outings with residents.[100] Brenda described a weekend trip to a holiday home. On this occasion, Brenda had taken inmates from Ward 3, female *schizophrenics*, mostly in their 40s or 50s:

> *I was the first one to go down there with 16 patients and fell over on a rock and broke my frigging arm … and here's me, with these patients who had never been away before. … I had this patient … she could really go off the air if she wanted to, but God she was marvellous. She knew there was a situation … I had dislocated my arm and they had to put it back in. At that time you could take your kids. If you had kids at home under school-age you could take them with you, and I had one of my kids with me.* [laughter] [101]

Brenda left her *pet* in charge of the holiday home for several hours while she sought medical attention. Upon her return she discovered that the patients had cooked and eaten, and that her child had been taken care of under the supervision of her *pet*. To give her a rest, Brenda's *pet* did the rounds of all the patients

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[98] The close working ties of psychiatric nurses are not unique: the potentially polluting nature of death underlies community suspicions towards palliative care nurses. McNamara examined how workers in the 'dying and death industries' tend to avoid talking about their work and instead draw support and understanding from within the palliative care 'community' (McNamara 2001:107, 113-116).

[99] Goffman writes that 'social mobility' between staff and inmates of the total institution is 'grossly restricted' (1961:19).

[100] It was also not unusual for the children of employees to become accepted into the asylum family. When she was five years old, Kerrie's mother died. Her father worked as an artisan at Kenmore during the Therapeutic Community era. Because her father had no family assistance with child-care, Kerrie would occasionally accompany him to work. The arrangement was informal and, therefore, she wasn't *seen*. Kerrie has memories of working on craft activities and eating lunch with female residents, of taking naps in her father's car while being watched over by a patient, of riding her bike after school in the asylum grounds. Kerrie felt accepted by and received a form of care from patients that she believes she never received from her relatives.

[101] In later years, Kenmore would routinely send two nurses on trips to its holiday homes.

throughout the night. And the following morning, she organised breakfast for the other patients.

Nurses' mediation of institutional rules and regulations in their informal encounters with cultural Others suggest that nurse-patient interactions cannot be generalised into a simplistic top-down flow of power. At times, nurses allowed the boundaries of this unequal relationship to become blurred in idiosyncratic ways that were reflective of the personal relations they developed with their charges. Nurses particularly valued those inmates who assisted them in the wards, who they referred to as their *trusties* or *pets*. These inmates were rewarded with cigarettes, additional food and where possible, with their own rooms. While they believed it was important to reward their trusties - *your best workers, of course you made an extra fuss of them* – they were mindful not to *spoil* them. Nurses acknowledged that it was inevitable one would favour certain residents over others, but they also believed one should not show such favouritism in an open manner as it could cause resentment amongst the other residents. Within the dynamics of this relationship, some residents may have used their 'pet' status and attempt to manipulate asylum rules and regulations to their own advantage.

The language used by nurses to describe their charges suggests they viewed themselves in a parent-child relationship. Family values were used by former Kenmore nurses to both illustrate and explain their personal relations with inmates and their occupational duties, for example, as variants of parental supervision, a view shared by both the York Quakers' vision of moral treatment and, 150 years later, the NSW Director of Psychiatric Services:

> The psychiatric nurse more than the general nurse is called upon to supervise many long stay patients in much the same way as a parent must supervise a child. Assistance is frequently required by a patient in feeding, organisation of daily living, programming of social and recreational activities. Once again, however, these are not duties which are unique to the psychiatric nurse. … many women who have raised families of their own fit excellently into this role of parent substitutes for psychiatric patients. (1963:11).

Breeze notes that a paternalistic (and maternalistic) response by the nurse is usually justified by invoking the lack of rationality and competence of the patient (Breeze 1998:62). Residents could thus be viewed as children, some of who had the capacity for being trained to live in the community, while others were regarded as chronically incompetent, never able to achieve adulthood and autonomy. The kinds of care which residents were likely to receive, then, were not only mediated by nurses' likes and dislikes but were closely connected to their evaluation of patients' capacities for autonomy. For example, nurses would select only those residents for outings who they believed could be trusted to behave themselves and who represented no threat to themselves or others:

> *Doris: Not all patients would be allowed to go into town would they?*
> *Linda: Well, not all patients were capable of going because, for physical reasons or psychiatric reasons ... if they were too psychotic and they were going to misbehave and make it very difficult ... probably abuse the public.*

Linda's comments suggest that, within this family formation there always existed the possibility of unpredictable and/or aggressive behaviour, even violence. For the childish qualities attributed to inmates were embedded in potentially volatile, adult bodies. Accordingly, at times the asylum was symbolic of a dysfunctional family of violent acts and punitive responses. Violence, or the threat of violence to self or others, imbued the asylum geography with an air of unpredictability and potential dangerousness. This understanding permeated Alison's description of night duty in the refractory ward: *The ward was an eerie place: dark, lots of corridors, lots of disturbed patients.*

In the context of an institutional setting for the detention of irrational, irresponsible and unpredictable inmates, the counting of knives at the conclusion of each mealtime was considered an important preventive ritual. At Kenmore and in asylums generally, the loss of a knife was viewed as a serious infraction of asylum regulations:

> It has been reported to me that recently a knife was missed in the Male Refractory Division, and that Attendants (Johnson) and (Payne) were responsible for the safe keeping of such knife. This is a most serious matter, and shows lack of supervision and responsibility on the part of these officers in addition to lack or consideration for the safety of the patients. I will investigate this matter on my next visit to the Hospital. Meanwhile, please inform all members of the Staff that such negligence will not be considered lightly, and impress upon them the necessity of greatest care and supervision.[102]

The asylum could be both a place of belonging, conducive to recovery, as well as a space of violent acts, resulting in a disciplinary and a punitive response. As long as residents complied with asylum rules and regulations, it could offer the lifestyle of the *Laborer,* of ordered routines punctuated by 'the rhythm of the days and the seasons'. At the same time, it could respond swiftly to any manifestations of *Savagery,* behaviours of 'immediate desire, without discipline, without constraint, without real morality'. According to one nurse, most acts of violence

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[102] Memo, Director of Public Health to Supervisor, New Norfolk, dated 10 August 1936; HSD290, Royal Derwent Hospital Staff Notices and Memorandum Book.

were self-inflicted. At the same time, all nurses reaffirmed Sandy's comment, that *(t)here wouldn't be too many staff here who hadn't been assaulted.*

Some residents resisted their confinement by committing violent acts towards staff, other residents and asylum property. At times, psychosis manifested itself in aggressive behaviour. Recollections of nurse-patient interactions in Kenmore include stories of violence alongside tales of asylum family picnics, of nurses being kicked and having commode contents thrown at them, of patients making *punching bags* out of the staff, of nurses being *knocked around* by patients, of nurses *wrestling* inmates. The ultimate act of violence, murder, is commemorated in the exhibition spaces of the Kenmore Hospital Museum: a former inmate returned to Kenmore and shot and killed a nurse in the 1920s. His target was the Medical Superintendent.

Nurses were authorised to regulate and contain the behaviour of residents. At times this involved the use of managerial techniques such as formal coercive strategies and informal, violent retaliation towards and punishment of recalcitrant, aggressive or destructive residents. Dwyer writes that, '(l)ike parents, attendants sometimes loved, other times struck out at, their difficult children' (Dwyer 1994:183). Kenmore nurses described what they referred to as preventive and self-defence strategies for dealing with unpredictable inmates. One strategy was to wet a tea towel, twist it and place it tightly around an inmate's neck.[103] This strategy was used to assist Joan when an inmate sat on her chest and placed her hands around her throat with a view to choking her.

Physical attributes of size and strength among nursing staff were highly valued, human resources for maintaining control over inmates. The desirability of these attributes attests not only to the prevalence of violence in the asylum but also to its custodial role in confining and controlling inmates. Roger described two nurses who worked in the refractory ward as *fighters, they were both boxers ... they could look after themselves.* Roger was not a fighter but during his time in Male 4, he always ensured he had the support and occasional assistance of *two patients that I could rely on, two blokes that you could trust*. Similarly, Sandy did not have the physique of a boxer, *but I was always a great believer in numbers. If*

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[103] This technique for restraining psychiatric residents is also described by 'Larry': 'Nurses named Billy Bunch and Anton McCall used wet towels around patient's neck so as to choke them without leaving a mark' (Gardner 1976:50).

I knew that someone was going to be coming in aggressive, I'd have backup, and big backup.[104]

The arts of surveillance were preventive mechanisms for managing unpredictable residents. Even subsequent to the widespread availability of psychotropic medications in the 1950s, nursing staff recognised that surveillance was the most effective technique for preventing violent outbursts:

> *In Female 4, all those scary women were all in the same dormitory together, all in that small dormitory. You'd go in there in the mornings, ... you would open the door, push it open and sort of stand back just to check out where everybody was before you went in! Because they were real big ... you just learnt to be kind of wary of some of them ...* (Alison, who commenced working in Kenmore in the 1960s)

The strategic placement of nurses within the ward was critical in maintaining visual contact with inmates. Roger recalled that nurses in the Male Refractory airing court were placed as follows: *there was always two in the yard. The senior man was up on the verandah and the junior man was down in front of the ha-ha wall.*

It was not only the nurses who feared violence but also the residents who at times were subjected to violent responses from nursing staff and other residents.[105] Elizabeth Gallagher complained of 'rough handling by staff' and of being struck by another patient. Nurses were reticent when it came to recalling any stories of colleagues' assaults on patients. While they were aware of incidents of nurse violence, they viewed them as exceptional and instead, emphasised a view that most nurses provided humane treatment and care.[106] They did suggest, though, that there was a correlation between patient violence and the

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[104] The *Report of an Inquiry into the Treatment of Psychiatric Patients at Graylands Hospital and other Psychiatric Hospitals in Western Australia* notes that: 'the care of psychiatric patients is an extremely demanding and sometimes dangerous occupation ....' They (the nurses) 'must protect other patients and themselves from the violence of some patients .... They experience frequent aggression and shocking verbal abuse from disturbed patients .... while the public is rightly concerned about the protection of the rights of psychiatric patients, no one cares to consider the difficulties which the nurses face every day they are on duty' (cited in Beaumont 1989:10-11).

[105] Violence of nursing staff against inmates has been widely documented in historical accounts and formal government inquiries. Allegations of staff assaults against inmates were widely publicised in the lead up to the Callan Park Royal Commission (Bromberger and Fife-Yeomans 1991:25-27). *The Report of an Inquiry into the Treatment of Psychiatric Patients at Graylands Hospital and other Psychiatric Hospitals in Western Australia* noted that 'there still exists an attitudinal climate in which violence by some members of staff towards patients is tolerated by other members of staff' (cited in Beaumont 1989:10-11). For a broader overview of violence, *The Report of the National Inquiry into the Human Rights of People with Mental Illness* (the 'Burdekin Report') discusses patient assaults on staff, staff assaults on patients, and patient assaults on patients (pp. 271-274).

[106] I do not wish to imply that this view is not accurate and correct. I do wish to suggest that it may also be related to their current role as Friends of the Kenmore Hospital Museum, as gate-keepers and interpreters of Kenmore's history.

attitude and behaviour of staff – or, indeed, that patient violence was provoked by the staff:

> *generally, if you treated patients well, you got similar respect back; there were some staff who used to "bait" patients, and when they went off the patients would target these kinds of staff.* (Linda)

In the course of her secondment to Kenmore's administrative section, Linda noticed that there were some staff members whose names were regularly featured in reports relating to assaults by inmates, while the names of other staff were conspicuously absent.[107]

Violence towards residents was not always overt but could take more subtle forms such as those described by Digby, including 'harsh words, rough handling when washing or dressing a patient, unequal apportionment of food or inappropriate exaction of employment' (Digby 1985:151). Margaret worked in Kenmore in the 1940s. She described watching a blind, elderly woman who, after stumbling in the shower, was pulled up by her hair by another nurse.

The arts of repressive and coercive care were justified by recourse to the patriarchal authority invested in asylum staff at the same time as acts of benevolence and kindness and a nursing narrative of belonging were articulated by reference to family values. These discourses of family, however, were mobilised in different ways in the Herd Care and Therapeutic Community eras.

Herd Care in the authoritarian family formation

The ordered routines of institutional life in the Herd Care era were core techniques of inmates' care and treatment. Military-like, disciplinary routines governed the formal interactions of nurses and inmates. Accounts of everyday life in the asylum have described the punctual adherence to time, the rigid routinisation of activities that governed the total institution (Goffman 1961:17; Digby 1985:148). The arts of care in this era focused on the custody and control of large herds of unruly, incompetent and unpredictable inmates. The ideal asylum nurse of the Herd Care era was one who embodied attributes similar to those articulated in the nineteenth-century publication, *Handbook for the Instruction of Attendants on the*

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[107] There was also implicit recognition within the asylum of the role nurses played in affecting residents' behaviour. Linda referred to a doctor who, after reported increases in ward *misbehaviour,* would ask for a list of nurses who had worked in the ward.

Insane,[108] of 'industry, order, cleanliness and obedience' and in other writings for the same period:

> If we could see in each of our attendants a well-principled person, intelligent enough to understand the reason of his rules, and the unreason of his patients, with sense of duty enough to make him do his work as well when we are away as when we are looking on; ... with tact and temper enough to get on smoothly and have his own way with them too; ... with self-control enough never to do more than blow some of them up, when they needed it; with observation enough to see and report the changes in their mental and bodily state to the doctor; ... if each of us could see all this embodied in each of his attendants, should we not feel as if it were an easy thing to manage an Asylum, and not so sad a thing after all to be insane? (Clouston 1876:383)

Nurses were expected to submit to gruelling routines of physical labour, be subservient to strict regulation and work long hours for low wages.[109] By virtue of their association with the mad and their largely domestic and outdoor work responsibilities, asylum nursing was a low status occupation. It is no wonder then, that asylum nursing was more likely to attract people with low levels of education, of working class and migrant backgrounds.[110]

Medical Superintendents generally reconciled idealistic representations of the asylum nurse such as those expressed above within the pragmatics of asylum practice. It was not unusual for nurses to be selected for attributes befitting a custodial institution, such as 'physical strength and stamina' and 'an imposing physical presence*'* rather than for their principles and tact (Smith 1988:306-7).[111] In Kenmore, sporting prowess symbolised attributes of physical strength. Roger worked at Kenmore for over 30 years. Formerly a warden of Goulburn Gaol, he described his first meeting with Kenmore's Medical Superintendent in the 1950s:

> *You didn't have to be good, but you had to play sport. I remember Dr B. I walked into his office – he had the old feet up on the desk, you know, smoking away: "Yes, what can I do for you?" "Look", I said, "I'd like to work out here." He said: "Do you play sport?" I said: "Yes". He said: "Do you play cricket?" I said: "Yes". He said: "Do you play hockey?" I said: "No". He said: "You've got to learn. Start next week." You know, that was it! If you came out here and you didn't play sport, well, sport was put out as entertainment for patients ... well, if you did play sport you were right!'*

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[108] The Handbook was written in 1885 by Scottish physicians of the Medico-Psychological Association (Nolan 1993:1198).

[109] See, for example, Smith 1988:301-327; Monk 2001:10-12; Scull 1979:122.

[110] Prebble 2005:3; Smith 1988:307*;* Dwyer 1994:171. O'Brien writes that asylum nurses' social background, in combination with the pessimism that pervaded 19th century asylums, partly explain why – unlike hospital nursing practice – there was no attempt to theorise asylum nursing (1999:131-2).

[111] Reynolds and Cormick write that the main role of psychiatric nursing up until the 1950s was the custody and control of inmates and that 'adequate physical stature and strength' was a desirable attribute (1990:3).

As implied by Roger's recollection, the 'getting' of asylum nurses tended to be an informal procedure.[112] While Kenmore's role as an institution of custody and confinement imbued it with an aura of segregation and self-containment, its organisational tentacles extended to people living in Goulburn and the surrounding region via the asylum's body of employees and their families. The asylum was a large employer and at any one time up to 400 people worked in its buildings and grounds. Margaret's family's history is intertwined with the stories of relatives who worked and lived at the asylum dating back to the early twentieth century. Seven of her family members, including siblings, cousins and aunts, were employed by Kenmore during the time of her employment. Margaret's story is not unusual. Most of the psychiatric nurses I interviewed had similar stories, of husbands and wives, siblings, parents and adult children who had spent most of their working lives at Kenmore.[113]

Nurses occupied an uneasy position in the Herd Care era for in common with their nineteenth-century predecessors, they were viewed 'as children themselves in need of continued supervision by the medical staff, as the surrogate parents of patients, and as the domestic servants of all' (Dwyer 1994:163). Because asylum doctors were forced to reconcile nursing standards with the pragmatics of running an asylum, nurses were not trusted to perform their duties in accordance with the prevailing rules and regulations. For example, as a consequence of his investigation into the abuse of inmates at the York Lunatic Asylum, Nicholl advised that:

> The keeper must himself be kept. If he be not watched and punished, an asylum is likely to be little beyond an alternation of reciprocal violence between the prisoner and the gaoler. (Nicholl, cited in Digby 1985:145)

An example of how nursing staff were subjected to scrutiny for the most mundane of activities is the guidelines for bathing residents in twentieth-century NSW asylums as set out in Appendix 1.

Like the asylum inmate, all aspects of nurse's working lives were subject to surveillance.[114] Nurses' appearance, attire, and work conduct came under

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[112] Dwyer, in reference to public asylums in New York (1994:170), and Moran, based on his research at the Toronto Asylum (1995:62), make similar observations.

[113] Similarly, Moran and Rosenberg (cited in Moran 1995) discovered 'networks of relatives' working in the Toronto Asylum and Michigan General Hospital. Moran suggests that relatives represented a major advertising and recruitment strategy for the asylum (Moran 1995:62).

[114] Dwyer and Smith write that asylum authorities sought to govern nurses as strictly as it ruled the lives of their inmates (Dwyer 1994:164, Smith 1988:310). See also Digby 1985:155. Mindful of the inmate perspective, Reaume warns against focusing too closely on the regulation of nurses' lives. He notes that, unlike nurses, inmates did not have the freedom to leave their wards, nor

constant scrutiny by those who had seniority over them.[115] Chapter 6 described the rule for staff working in Kenmore's Male Refractory Ward, of being required to turn a key for a box at 15-minute intervals during night shifts, thereby confirming staff diligence in performing their night rounds as well as the ward's security. The following excerpts of communication from the Medical Superintendent to staff of New Norfolk Hospital, Tasmania provide further illustration of some of the different ways nurses were expected to conform to asylum regulations:

> 14/12/36 Please instruct the attendants when out with working gangs that they are not to stand about smoking and talking, but to instruct and assist the patients in the performance of their work.
> 27/8/37 From observation it would appear that Attendants are becoming neglectful of their appearance. As previously instructed, they must be shaved before 10.30 a.m. daily, and correctly dressed with collars and ties, etc. Artisans, of course, must likewise be shaved daily, but are not required to have collar and tie on whilst working. If this instruction is not carried out, action will be taken against the offenders.
> 25/7/38 Deputy Charge Attendants are reminded that on account of their position they are expected to exercise the necessary discipline and supervision over the more junior attendant working under their direction. I am of the opinion that this has not been the practice and I wish to inform them that unless they are prepared to undertake this responsibility, I shall recommend that they be disrated back to the position of Attendant.[116]

The 'training' of asylum nurses took place in Kenmore and was governed by the institution's logic of discipline and order. It was unusual for nurses to *take the veil* in the Herd Care era. It was also believed that the discipline of nurses' working lives inculcated within them the rigour of care:

> *Julie: She got down on her hands and knees under the fire grate and she found some ash left there. So she berated me for half an hour in front of all the staff about how I could never be trusted to be a good nurse because I would forget how to give people injections, forget what dosage, you know, blah blah blah ... because I could not be trusted to clean that fire.*
> *Linda: You see, her idea of training you was teaching you to forget nothing. When you cleaned something there, ... you didn't put the polish on the door knobs and leave it there, you polished it as you went ... because you were in an admissions ward, you could be called away at any moment, so you had to finish everything as you went.*

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were they appropriately remunerated for their labour in and around asylum grounds (Reaume 2000:74).

[115] The regulation of asylum nurses was not unique to the psychiatric profession. There are some overlaps between the organisational culture of the asylum and the general hospital. Asylum and hospital-based nurses shared working conditions of apprenticeship training, shift-work, living-in requirements, and hierarchical organisational structures. Rank differentiated and ordered nurses as rigidly as diagnostic classification schemes ordered patients and inmates (Castle 1987).

[116] HSD290, Hospital Staff Notices and Memorandum Book. Similar Documentary evidence of communications between the Medical Superintendent of Kenmore and his staff for the same period is not available, and it is for this reason that archival material from a Tasmanian asylum is used to provide illustrative examples of nursing staff regulation.

Apart from patient labour, some occupational therapy, Christian religious services, Talking Pictures, and monthly dances, Kenmore inmates were provided with little social, mental or physical stimulation: *boredom was endemic*.[117] Nursing 'included little more than a caretaking custodial function', the main objective of which was 'to contain patients, keep them in reasonable physical health, and prevent patients from harming themselves, other patients, and staff' (Reynolds and Cormick 1990:3).

The ideal nurse was a distant, authoritarian figure, one who was not expected to get to know his or her charges. The 'efficient "keeping" of residents, rather than ... interaction with personnel' was a core feature of Herd Care (Wolfensberger 1975:8-12).[118] Only Charge Nurses had access to individual case notes. Nurses were informed of inmates' backgrounds only if they were viewed as potentially suicidal or homicidal or as escapees. An example of the distanced relationship between nurses and their charges was provided by Joan, who recalled the case of a female inmate whose body, it was discovered subsequent to her death, was riddled with nits and body lice. The heavy burden of domestic chores that formed part of nurses' daily routines also precluded them from forming close relations with the residents.

Unlike Dwyer, Monk does not 'see a contradiction between the domestic and therapeutic work required of attendants' because the routinised and domestic components of nurses' working lives both supported and maintained the moral environment that 'would return the mad to reason' (Monk 2001:69-70). She adds that, at least for male attendants, the domestic workload that dominated nurses' lives was transformed from 'the feminine and private work of "nature, nurture and non-rationality" to the masculine and public work of reason: a rational, cultural

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[117] Claire's recollection of nursing in Kenmore 1959-60.

[118] Reynolds and Cormick note that, with the widespread availability of psychotropic medications in the 1950s, 'many patients became considerably more accessible to nursing staff, leading to the formation of a variety of nurse-patient relationships ... (in) an unstructured, unsystematic and random way' (1990:4). O'Brien suggests that the growing involvement of nurses in physical treatments such as cardiazol, electroconvulsive therapy, insulin and leucotomy should also be considered as factors in the 'reconceptualisation of their role as contributing directly to treatment' (O'Brien 2001:134). The gradual medicalisation of the asylum also had repercussions for the professional development of psychiatric nursing. Based on historical research of New Zealand psychiatric nursing, Prebble found that these trends not only expanded nurses' psychiatric nursing repertoire in both clinical and therapeutic techniques but also enhanced their occupational status (Prebble 2005:5). Similarly, Dooley notes that nurses of Brandon Hospital in Manitoba began to administer new medical therapies in the asylum and conduct intelligence tests in schools in the 1930s and that while these new techniques of treatment and care represented only a minor aspect of their work, they were relevant to bolstering 'their sense that they had a credible claim to the title of nurse' (Dooley 2003:244).

Plate 12: Example of patient labour Kenmore Hospital – stones quarried locally and used for the erection of landscaping features Photo: D Kordes

Plate 13: Landscaping feature, example of patient labour, Kenmore Hospital 2005
Photo: D Kordes

and intellectual endeavour' (Monk 2001:70). It is questionable, though, that nurses experienced these onerous tasks, such as the following example of some of the morning chores, as therapeutic activity. Kenmore nurses referred to daily routines governed by time, for example, *(t)ea at 4.30, supper at 6 and the worst ones went to bed at half past 5*. The first task of the day commenced at 6.30 a.m. when inmates were woken, ordered to remove their clothing, and mass showered. Some of these routines persisted into the Therapeutic Community era, for example, Julie recalled her first day at Kenmore in the early 1960s:

> *my first sight was of all these oldies getting out of bed and heading off to the showers. Because they were all incontinent they would strip at the bedside. ... Take their night-dresses off, ... I had never seen a naked woman in my life before. And I just wanted to cry. Because here were 40 of them ... I didn't know what I'd let myself in for. I walked into the shower area and there were all these naked bodies. It was like something out of Belsen.*

A physically demanding task associated with the mass showering of inmates consisted of both carrying and rolling a coir mat of over nine metres in length and soaked with water, urine and faeces outside the bathroom, hosing it down and letting it dry out. In addition,

> *we used to go down and clean the basins and the baths. There was one bath in each ward, I think, and there were these ... black enamel benches with these basins in it, you had to clean them all with kerosene - you cleaned everything with kerosene, and then you'd rush up and be ready for breakfast.*[119]

Roger described the herd-like activity called *shaving day*, which took place twice a week:

> *you'd have a big long day, you'd line up, with your (buckets of) hot water, your cold water. To start it off we used to use blades ... so you'd scrub those. Then you went off with the blades, with the proper razor blades. We needed to have, we had to have one patient, lather them up, and he'd come along the line, ... and the staff member would shave them.*

Breakfast was transported from the kitchen between 7.30 and 8.00 in a horse and cart. Before the arrival of the Medical Superintendent and Matron on their rounds, which commenced at 9.00, the kitchen had to be cleaned, knives counted, windows had to be spotless, the back steps scrubbed, and pig tins scrubbed and

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[119] Kerosene was the main cleaning and polishing agent used in wards and was integral to nurses' daily lives: *you cleaned everything with kerosene*. It was used as a fire lighter. Kerosene lamps provided lighting at nights for staff in the wards. And when the kerosene tin was empty, it was recycled as a container for food and fuel supplies. 'Sandy' described his fear of a ward going up in flames, particularly at night when patients were supposedly asleep in their beds and ward rounds were conducted only every two hours: kerosene was used on most surfaces and most inmates smoked.

polished up with kerosene. The fuel stove was also cleaned and polished up with *black.*[120]

The segregative routines of Herd Care relaxed in the context of the permissive era heralded by the open door, integrative policies of the Therapeutic Community approach. The differences between these two variants of care are visible in Roger's recollection of the mundane activity of getting inmates to the pictures:

> *Roger: You might have 100 patients who want to go to the pictures ... usually there were people rostered for picture duty. Now, those blokes who were rostered on picture duty used to go up to the theatre ... and um, the staff of each ward used to take them through until they got to Ward 1. ...* [This entailed the placement of staff at strategic checking points.] *You'd line them up, and they'd come into the theatre, and then they'd hand them over. There might be, might be four female nurses* [and four males] *on duty. And when the staff from the wards brought them and put them into the hall, they went back to the wards where they'd left the people inside the wards* [not all patients went to the pictures] *to more or less look after them. But it was funny, you know, men to the right, women to the left. No one between. In between them was the staff. 'Where do you think you're going? Get back into place!'* [laughter]
> *Doris: But did that change with integration?*
> *Roger: Oh yes, gee whiz, they were – "who wants to go to the pictures?" You'd let them outside the door and away they'd go. No staff member, you'd just let them go ... That was when things eased, you know ... when they were more or less given the freedom, you know, to be let outside the door.*

Therapeutic Community in the permissive family formation

The shift from the locked door regime of Herd Care to the open door approach of Therapeutic Community involved not only the creation of a therapeutic environment but also a change in the attitudes, knowledge and practice of nursing staff. The Therapeutic Community regime encouraged closer interaction between staff and inmates.

Bloor *et al* have described therapeutic work as an 'activity which can transform any mundane event ... by redefining that event in the light of some therapeutic paradigm' (Bloor *et al* 1988:5). In Australian asylums, group activities were devised with the view of instilling within the residents a 'community factor' (Dax 1961:76-77):

> Daily groups are an important aspect of maintaining an efficient therapeutic environment. ... The psychiatric trained nurse with her positive ability, initiative and enthusiasm encourages the cohesiveness of the group. ... Patients are given positive and realistic feedback at times under the guidance of the psychiatric nurse (Latham 1981:53,56).

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[120] *Black* refers to boot polish. *Black* could also refer to a combination of shellac and boot polish that was applied on ward staircases (personal communication with Leoné Morgan).

While domestic and cleaning responsibilities had been alleviated by the introduction of cleaners and nurse aides into the asylum, psychiatry recognised how these activities could continue to have a role within the therapeutic paradigm of this era by inviting the patient's participation. Domestic activity represented an opportunity for retraining and resocialising inmates and for monitoring their progress. The nurse could transform the profane acts of cleaning into sacred arts of therapy:

> It may be useful for a member of the nursing staff to clean the windows of a ward, but only providing she has a group of patients with her, for then she should systematically use this contact with the patients as a means of non-verbal communication and be prepared to report upon how they have worked, communicated and reacted together as a result of her efforts. Thus for a nurse to be sent out to clean the ward windows herself is obviously unsatisfactory and is a non-nursing duty, but as soon as she has patients with her it becomes a therapeutic contact (Dax 1961:81).

In Kenmore, some of the group activities run by nurses replicated a family mode of interaction:

> *But Brenda had a real casual atmosphere, like, she was a funny bugger wasn't she, she, you know, she'd scream and yell and tell them to get fucked and all the rest of it, and they adored her. And, every afternoon after lunch, as soon as washing up was done, they went to the sitting, the little sitting room that she made. It used to be the old dining room. And they'd watch 'Days of our Lives'. She'd be sitting up there, and they'd all be sitting around the floor there. She was like a mother hen.*

In 1963, the Director of State Psychiatric Services asserted that nursing practice not only entailed 'domestic work, basic nursing care, and parental supervision', but also included 'technical psychiatric nursing'(SPS 1963:11). He applauded the development of a new curriculum for training nurses 'in the technical procedures of counselling, remotivation, rehabilitation and even, psychotherapy'. At the same time, 'general servants' were employed to take over some of the domestic chores previously the responsibility of nurses (SPS 1963:11).

The redefinition and expansion of psychiatric nursing practice placed additional stresses on staff because it involved a relaxation of some of the custodial practices of Herd Care and the introduction of new freedoms and activities in the asylum. Some nurses did not adapt readily to the new occupational expectations placed upon them. The Director noted, for example, that the 'extension of the liberal approach towards the management of ... the longer term patients has in some areas been rather tardy. On the other hand, it is necessary to hasten slowly with this problem, to enable staff to adjust their attitudes to the new demands made upon them' (SPS 1963:7). The introduction of the Therapeutic Community approach also created tensions between different generations of staff: '(m)any of the more experienced and older nurses have felt threatened by the consistent demand for the adoption of new techniques and new attitudes towards the management of long stay patients' (SPS 1963:10).

The Director's comments suggest there was reluctance amongst some nurses to abandon entrenched practices of custodialism. One of the reasons for this reluctance was that the implementation of liberal care practices imposed additional responsibilities on nurses. At the same time, nursing practice became a more complex occupation, involving an increased repertoire of technical skills. While nurses' domestic workloads were gradually reduced, they were now expected to run activities programs specifically designed to resocialise and prepare inmates for the freedoms of living in the community. As part of their training, a greater number of residents were given freedom of movement on the asylum's grounds. At the same time, nurses remained responsible for their charges and were subject to formal repercussions if they escaped:

> *I mean, I've had the experience of losing two patients … they didn't know where they were going, they just wandered, and we searched and searched and … finally one woman was found way out in the paddock. And this was when doors first became unlocked, and people didn't understand the responsibility they had.* (Linda)

Although institutional life continued to be governed by routinised group activities, staff began to recognise the therapeutic importance of treating patients as individuals, of recognising that *different people had different needs.* In contrast to the Herd Care era, nurses were encouraged to talk to patients, and novel, individualised care techniques were implemented, for example, where residents would:

> *have a bath one-on-one with a nurse at least once a week. And in that time the nurse was encouraged to spend time talking to that patient, shampooing their hair, doing their nails, generally talking to them and helping them … to look after their own personal hygiene. And then they'd set their hair if it was a girl …* (Linda)
>
> *Then, more formal dances (balls) were held in the main hall. 'The Ladies' would be assisted to 'look their best'. The hospital provided hair dressers and we would make sure personal hygiene, make up, gowns, jewellery were made available to every patient in our ward. I was not rostered in male wards then. Nevertheless they also looked their best on these occasions.* (Caroline, who commenced working in Kenmore in the 1960s)

Under the influence of Therapeutic Community, a more permissive family formation slowly emerged. With the introduction of greater freedoms, it was not unusual for groups of inmates and staff to go on regular excursions outside Kenmore's boundaries. The Kenmore Staff and Patients Amenities Association purchased holiday homes at the beach. The Association contributed 50% towards the purchase of a 43 seater bus in 1966, and the remaining 50% of its purchase price was paid by the Department (SPS 1964-66:31). The *Big Kenmore Bus*, as it was referred to by a former Kenmore nurse, transported patients into the community, on recreational and shopping expeditions to Goulburn, to other towns and tourist attractions in the region, and to the beach for holidays. One of the main objectives of trips outside the asylum was *to socialise patients with the general community* (Caroline). This era in Kenmore's history is one that evoked happy memories for staff:

> *We had some good times. ... the bus was there for our convenience and we went out every day ... it took 40 or 50 patients ... we used to go to the coast a lot, take them down to the beach ... or we'd go to Canberra or we'd go to the zoo or ... we used to go to those theme parks and ... we also used to have a holiday house down at the coast ...*

It also evoked happy memories for some of Kenmore's former patients. Leila was involuntarily detained at Kenmore in the late 1960s. She recalled that, in addition to being rostered to do certain jobs on the ward such as mopping the floors, she went to art and craft classes, played tennis and bingo, attended BBQs and went to dances on Friday nights. In Leila's words, *I liked Kenmore Hospital because as I was getting better, I had fun there. I was on the social committee.*

Increasingly, staff were mobilised and dispersed within community settings, taking with them the arts of care they had learned in the asylum. The training of domiciliary nurses commenced in the mid 1960s, and provided discharged patients with 'continuing assistance and supervision' (SPS 1968:4).

> *In 1971 I was deployed into another nursing service, that is, domiciliary nursing. This service followed up patients on leave or discharged from Kenmore Hospital. My duties were to visit the patient at their home* [and] *offer support in any areas of "life skills" the patient required.* (Caroline)

In addition to providing support, domiciliary nurses also provided 'medical scrutiny beyond the hospital and into the home' (Rose 1988:75), representing a widening of the psychiatric lens to capture those family members who had hitherto not come under its surveillance.

Gender Integration

A core component of the permissive Therapeutic Community era was the integration of the sexes, for both nurses and inmates.[121] The refurbishment and integration of Male and Female Intermediate Wards 3 in 1963, referred to in Chapter 6 represents Kenmore's first efforts in creating residential therapeutic communities. The rationale for integrating the sexes was their resocialisation and, ultimately, their discharge into the community. Nurses supervised the interactions between the men and women who had, up until then, led segregated lives:

> *They didn't exactly mix as such, ... like there'd be a table of men here and a table of women here ... and that's the way you had to treat these people, you had to introduce them slowly, real slowly, even with moving them, take them on ... little morning teas and then maybe a day visit, you know, continual small, small increments of exposure if you like.* (Joanne)

Integration was a major adjustment for both staff and patients. Roger, a young single man at the time, described his first day of commencing duty in a female ward:

> *I was one of the first males to go over on the female side ... half past 6 start: "come on, upstairs." I said: "I'm not going up there." "Oh yes you are."* [The women were upstairs, stripping down in preparation for their showers.] *"Oh, a man!!" was the response from the female patients. They probably hadn't seen a man for bloody 20 years, 30 as far as I know! They were in shock, you know. ... But you were classed as a nurse, and you had to do what a nurse does. ... It was the same thing when the females came over here. They started over here and it took a while to get used to. ...*

Interviews and group discussions with Kenmore's former nursing staff revealed that male and female nurses ran their wards differently. Until the 1960s, Kenmore was physically divided by gender and this division affected both staff and inmates:

> *Julie: We didn't even share a sitting room after meals. The men had to go to their rec. room and we had our sitting room.*
> *Doris: And you could spend your whole day not seeing a man?*
> *Julie: Oh yes, no problem at all.*
> *Linda: Unless it was a doctor ... you weren't encouraged to fraternise with the men. ... the only way I got to know them was on picture duties and dance duties.*

After wards had become integrated it was apparent to both sexes that gender norms had shaped and continued to shape work routines and ward cultures. Female nurses tried to make things *nice* for their *girls* because they believed an orderly and feminine domestic setting would not only encourage the restoration of

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[121] Not all wards became integrated. A decision to integrate was dependent upon patients' capacities for moral responsibility or, alternatively, their incapacity to behave inappropriately (for example, where patients were severely, physically disabled and deemed incapable of engaging in deviant activities).

inmates' sanity but would also produce better behaviour. The ideal nurse was thus a role model of civility and her efforts of restoring culture to residents were reflected in modifications to the ward surroundings. At times, asylum doctors recognised Charge Sisters' efforts in providing a moral environment for residents:

> *She used to entertain the doctors for the doctors' meetings and the tribunals and everything because she had the prettiest ward ...* (Linda)

Female nurses suggested that their male colleagues relied more on patients' assistance in keeping wards clean and were less vigilant in keeping a high standard of cleanliness and patient care. According to Sandy and John, while female wards tended to be *pretty* and *homely*, male wards were run more efficiently and effectively.

One could speculate that there was an informal acceptance at Kenmore of different standards for male and female wards, and that men were not obliged to keep their wards looking *pretty* because this kind of activity was not in accordance with the norms governing masculine behaviour. In general, men tended to occupy themselves doing *boys*' *fun stuff* such as playing billiards and table tennis with the patients while the women tended to focus on engaging with inmates in typically female work. Part of this included providing residents with feminine attire. Linda described one occasion when she brought in her wedding gown and bridal veil for inmates to wear to a ball. It was not unusual for nurses to bring in their old jewellery and make-up for special occasions.

After integration, some female nurses were initially baffled by their discovery of the extent to which gender norms were replicated within nursing practice:

> *Joanne: The boys used to have a standard issue of a book in the back of their pocket, and they'd go out in the sun. That's what they used to do for most of the day.*
> *Doris: They'd read?*
> *Joanne: Yeah.*
> *Doris: And what would the female staff do?*
> *Joanne: They'd be doing what women do, I guess.*
> *Doris: Working?*
> *Joanne: Yeah.*
> *Doris: Cleaning?*
> *Joanne: Yeah! But not so much cleaning in my day. There was more, like if they had balls and things like that. We would be preparing clothes and doing their hair and, you know, all that other stuff ...*
> *Doris: So male and female routines in the outside, in the real world, they were reflected in the ...*
> *Joanne: Yeah, yeah, absolutely.*
> *Doris: Isn't that interesting?*

> *Caroline: Yes, it is interesting. And I got a bit of a shock, cause I thought, it's still a hospital, you'd still have routines.*
> *Joanne: And these people need caring for and they can't have broken flies and missing buttons and rips in their dacks* [trousers] *and things, you know.*

The integration of sexes in Kenmore marks a distinct rupture from the moral treatment regime developed at the Retreat. The segregation of the sexes in nineteenth century asylums was intrinsic to the practice of moral treatment. In practice, however, it may have encouraged 'deviant' behaviour.[122] Residents' basic human needs of physical touch were at times met by indulging in same-sex relations in the asylum. Nurses referred to the prevalence of homosexual activities among female residents, of morning shift staff finding women in bed together. Male nurses did not mention any homosexual practices among their male charges. They only brought up the thorny issue of sex in the asylum when it was connected to their supervisory role in managing interactions *between* the sexes. Neither males nor females brought up any incidents of sexual relations between staff and patients, although female nurses alluded to sexual offers they had received from residents, and to the policy that male staff work in pairs to protect themselves from claims of sexual abuse from female patients.[123]

One could suggest that, while it marks a rupture, integration is not incompatible with the normalising tenets of moral treatment. The new relations fostered by integration provided the asylum family with an authenticity and legitimacy not available in a gender segregated asylum. Prior to integration, each ward family was reflective of a same sex, household formation. The merging of the sexes, then, reaffirmed a nuclear family ideal by fostering the normalisation of male and female interactions and facilitating residents' incorporation within a social arrangement in which they had recourse to both a mother and a father figure:

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[122] 'Megan', a parent, notes that 'during my, and my daughter's stay at Everville lesbian activity presented itself as a problem. The wards are locked at night and no one really supervises the residents. This can cause problems for those people who do not wish to submit to the females' advances.' Megan then goes on to describe the practice of gender segregation at 'Everville, a pseudonym for an Australian asylum: 'separation of sexes probably causes more problems than it solves. Many of the female patients in with my daughter were overly interested in the fact that there was a male ward next door. A more natural, healthy attitude towards this problem would probably be of far more benefit to the patients, instead of treating them like unreliable children' (Gardner 1976:56).

[123] Accounts of sexual assaults in psychiatric facilities, by patients or by staff, are not uncommon. See, for example, *The Report of the National Inquiry into the Human Rights of People with Mental Illness*. (Burdekin Report), 1993; and Davidson, *Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions,* 1997.

> *Roger: It was a good thing in one respect because, ah, the patients, they changed too, in their outlook, you know. ... Their behaviour had to change as well as ours. Now sometimes, say there were two – there'd be a male and a female nurse in the yard. And the patients couldn't carry on the way they were carrying on when there were only males in the yard.*
> *Doris: They pulled themselves together?*
> *Roger: Oh I think they did. Well, ah, it's a father, mother relationship, if you know what I'm talking about. If a girl was in the ward, say, an elderly nurse, a girl, she was in a kind of motherly relationship with the patients, you know what I mean, and vice versa, so it happened for males who would look on myself as a father ... I don't know what it was, but it definitely changed them, it changed their attitudes. Oh, it was respect, I think, I think that's what it was, a father-mother relationship, ...* [But] *it took some getting used to.*

The decline of the asylum family: 'it was the younger generation that came on'

During the 1970s and 1980s, the structures of nurses' working lives were altered in accordance with new ideas on their education, training and professional practice. It was no longer compulsory to live in nursing accommodation facilities on Kenmore's grounds. Asylum-based training was phased out by the 1980s, and students attended tertiary institutions to gain their qualifications in nursing. The informal system of seniority was replaced by formal promotion procedures. Together, these changes contributed to the decline of the asylum family.

The old notions of rank within a hereditary scheme of promotion were replaced by new rules for promotion. In interviews and group discussions, the practice of seniority was frequently associated with *the good old days* when *staff looked after one another, protected one another*. If someone had commenced work at Kenmore a day earlier than another colleague, they were automatically given seniority over him or her. A system of meritocracy replaced the long-standing expectation of inheritance. Although the system of seniority relied on staff deference and submission to a rigid hierarchy, according to older Kenmore nurses it also fostered a sense of family and camaraderie and a strong sense of loyalty to the work place:

> *When it was seniority, everybody knew who was next in line. There was no bitchiness and no competition and rivalry or anything like that. But after, oh it became bitchy. You know, people would think they should have a job but somebody else got it.* (Brenda)

The new procedures for promotion exacerbated tensions between the sexes. Older male nurses were forced to accept the possibility of working for a younger female with less nursing experience at Kenmore. Feelings of resentment among male and female staff were also aggravated by the introduction of equal wages at the time wards were becoming integrated. Several of the female nurses I interviewed were told by their male colleagues that *you should be at home looking after your children … your children need you*.

One way in which the decline in the asylum family manifested itself is in the end of Kenmore's sporting era:

> *we used to have table tennis teams, we had cricket teams, hockey teams, … we used to play badminton up in the hall, all that went, just because the younger staff just weren't interested. ... it went completely out the door.* (Roger)

Both the period leading up to the publication of the Richmond Report in 1983 and the aftermath of its recommendations challenged the legitimacy of the family formation:

> *Roger: Then the meetings started, more meetings than flaming God knows what. ... And they used to say "well, leave the patients out there – we're going to a meeting ... oh, it was terrible. Meetings, meetings, meetings, meetings! You know, "dash the patients, they're alright, they're out in the yard." I don't know, it was the younger generation that came on.*

The shift in nurses' training outside the perimeters of the asylum had introduced a 'younger generation' of nurses with no allegiance to the close-knit work culture fostered by an older generation of nurses. The new generation of staff had received training in the arts of care that were congruent with the values of community psychiatry. Their arrival heralded the demise of the family formation of the asylum.

At the same time, the work of allied health professionals increasingly overlapped with nursing practice, while psychiatric nursing became increasingly fragmented and more closely associated with specialisation in the techniques of medicine. Ron Brown, Principal Nurse Educator at Kenmore, contributed to a debate amongst psychiatric nurses on questions of occupational identity as follows:

> Are we merely mothers preoccupied with feeding, bathing, washing clothes and counting linen? Are we merely mini occupational therapists, mini industrial officers and the like? Who then will feed and bathe? Who will give out medication? Who will tuck patients into bed? Who will take activity groups? (Brown 1979:p.n., emphasis in original)

Ten years later, the debate had not abated:

> The increasing involvement of social workers, occupational therapists and welfare officers in the management and treatment of psychiatric patients has led nurses to feel that they have been deprived of professional responsibilities and left with less satisfying tasks. (Beaumont 1989:10-11)

The questions of occupational identity continue, framed in the discourse of professional boundary setting. Dianne, a former Kenmore nurse aide who commenced working in the asylum in the 1980s, accepted that registered nurses should have technical responsibilities for medical treatment and care but questioned why some nurses did not like to see her spending too much time talking to patients. She believes that nurse aides are not encouraged to deviate from their menial tasks of cleaning and feeding because:

> *we're not nurses ... It's all down to a piece of paper. OK. They're saying, 'cause they've got a piece of paper … and we don't, therefore we haven't got any jurisdictions. But, you know, I know how to take blood pressure, I know how to do all these things, and they know I know, and they're frightened that I'm going to take over their jobs. … I don't want to take their jobs over!*

Dianne currently works in a group home, away from the rigidly imposed rules and regulations of the institutional settings of asylum and hospital where she engages with her clients in a way that is reminiscent of the therapeutic relationship described by Reynolds and Cormick:

> *See I'm lucky here, now I'm in the community, ... we can stop and talk to these patients, you're allowed to sit down and talk to them, make them feel good and say 'hey would you like me to get you this, can I do this for you', ah, hold their hands if it's necessary. Go out of our way. And there's no pressure put on us … 'you're not meant to do that – that's not in your job description.'*

* * * * *

This chapter discussed nurses' accounts of working in the asylum during the Herd Care and Therapeutic Community eras. Nurses in both eras described the dynamics of care by evoking the narratives of authoritarian and permissive family formations. I described how the mundane interactions between nurses and asylum residents were transformed into the sacred through the invocation of the therapeutic relationship. At the same time, I proposed that the relations between nurses and their charges at times mirrored the dynamics of a dysfunctional family and at other times provided both nurses and residents with a sense of belonging. In Section 4, I consider how the arts of Herd Care and Therapeutic Community 'make up' the possibilities for action of the inmate and the patient. In the chapter that follows, though, I sustain this Section's focus on the relationships of care by analysing the rise of the carer in the Community Care regime.

10. The Rise of the Carer in Community Care

The shift to community has involved the creation of new roles and responsibilities for agents of government, and one of these is embodied by the policy creation known as the carer.[124] In this chapter the roles of carers are explored through their experiences of guilt, shame, stigma and the 'burden' of care; through their interactions with mental health professionals; and through the dynamics of relations between the care-provider and recipient of care.

The paradox of families as carers

The institutions of asylum and family have at various times been attributed with both psychopathology and cure. Campaigners for the asylum solution contrasted its therapeutic capabilities with the inadequacy of poor, working-class families to provide appropriate care for the insane, such as the case of Mary Jones in Wales who was discovered living:

> On a foul pallet of chaff or straw … in a dark and offensive room over a blacksmith's forge … here she had been confined for a period of fifteen years and upward. She was seated in a bent and crouching posture on her bed of nauseous and disgusting filth.[125]

In twentieth-century Australia, Dax and Hagger described 'multiproblem' families and their homes:

> are usually neglected and unhygienic, there is little household routine, meals are unpredictable and irregular. Fights between intoxicated parents are commonly witnessed by the young (Dax and Hagger 1977:227).

From the 1940s onwards, social psychiatry turned its attention to the family, linking aetiology with 'child rearing and family environment', its growing popularity influenced by the rise of new helping professions such as social work that tended to use family dynamics, for example, 'dysfunctional socialisation' and 'maternal deprivation', to explain broader post-war concerns of poverty, crime and juvenile delinquency (Hatfield 1987:9; Pejlert 2001:194; Symonds 1998:36). The development of new terms such as the 'schizophrenogenic mother', coined by Fromm-Reichmann in 1948, and the 'schizophrenogenic family', suggested by

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[124] The term 'carer' is not universally accepted and may be contested (Heaton 1999:768). For the purpose of this discussion I use the term carer as it is defined in the *Caring for Carers Policy Discussion Paper*, Appendix D, that is, as 'unpaid informal carers – those who care for a relative or friend without payment other than a pension or benefit. It does not include paid care workers or volunteers arranged by formal care services' (Department of Disabilities, Housing and Community Services [DDHCS] 2003:5).

[125] Hansard 81, 3rd series, 1845 cols. 185-186, cited in Scull 1983:331.

Laing in 1960, symbolise its preoccupation with studying the family as potential site of social and psycho- pathology (Fromm-Richmann 1948:263-273; Laing 1960; Laing and Esterson 1964). The family therapy approach emerged as a technique for observing and measuring the impact of family dynamics on persons diagnosed with a psychiatric dis-order (Jones 2002(a):24- 27).

While the asylum solution has been discredited in public policy discourse, the role of the family as a causal factor in psychiatric dis-order has been downplayed and the psychiatrically dis-ordered have been returned to the social setting that has historically been regarded as a potential breeding ground of psychopathology. At the same time as the shift to community solutions has placed the psychiatric profession in a stronger position to extend its gaze and identify and treat symptoms of psychopathology in the wider population, it has also placed greater expectation on the private sphere of the family unit to provide care and accommodation. Care in the community would address these dynamics because, assisted by a growing band of psy-professions, an optimistic psychiatry could potentially treat all heretofore neglected members of the family unit:

> Maintenance of the patient in his family group could result in treatment of the total group. ... Removal of the patient from his social milieu in treatment elsewhere results frequently only in symptom removal and on recovery from his particular illness he is precipitated back into this atmosphere ... which in the first place precipitated his mental illness. Treatment in his environment will guarantee that these factors too are attended to. (Frame 1966:18)

At the same time as psychiatry extended its gaze to the ‘family group’, the family was given a greater role by government in the care of its relatives. As discussed in Chapter 6, fiscal considerations merged with the moral persuasiveness of consumer rights and freedoms and it is these arguments that have legitimised care *by* the community. One of the reasons for the omissions and silences within government of families’ roles in the psychopathology of their relatives, then, may be its reliance on an unpaid work-force that contributes to reproducing the care regime of Community Care. In 1998 carers in general saved the Australian community a conservatively estimated amount of $16 billion per annum. In that year, ‘74% of people who needed assistance with self care, communication, housework and meal preparation were assisted by informal (unpaid) carers’ (Department of Disabilities, Housing and Community Services 2003:7-8).

Hancock argues that the deregulation of the labour market has led to greater income instability which, in combination with a changing Australian demography, contributes to a ‘care crunch’ (Hancock 2002). The ‘male breadwinner/female carer household’ model is ‘unravelling’, and accounts for approximately only one third of Australian families (Hancock 2002: 121,125). By 1999, more than 25% of the workforce had become casualised, while those working in full-time jobs were working longer hours (Campbell, cited in Hancock 2002:122; Hancock 2002:124). In addition, household and family projections for 2001-06 suggest that lone person households will represent the greatest increase in households, between 57-105%, from 1.8 million to 2.8-3.7 million in 2026 and the population group 75 years plus will double to 10% of the Australian population (Australian Bureau of Statistics 2004). Combined with declining fertility and marriage rates and increases in divorce rates and lone-parent families, these trends will ‘result in an unevenness in the capacity of households to cushion lifecourse transitions’ (Hancock 2002:127). Paradoxically, ‘(j)ust as these intensified expectations are put on the family, it is less capable of delivering them’ (Hancock 2002:127). Yet the policies of Community Care are grounded in the implicit expectation that the family is prepared, ‘available and ready’ to care for family members (Opie 1992:187,194).

Canberra Mental Health Carers

In the Community Care era, Canberra families no longer have recourse to institutional, long-stay solutions such as Kenmore. Reconceptualised in policy language as carers, families have been invited by government to become agents in the management of their relatives’ mental conditions. In the course of fieldwork, in public forums and private meetings in community settings, the ideal carer emerged as a subject imbued with a specific form of agency: able and prepared to take on the surveillance of the psychiatrically dis-ordered, skilled in mental health literacy, and knowledgeable in the arts of accessing mental health services.

The term carer denotes the provision of informal care, that is, unpaid care provided ‘out of love and filial piety’ (Heaton 1999:765). Heaton locates the first references to informal care in 1976, in the bibliographic database, Medline (Heaton 1999:762). In Canberra, one in seven people are carers. This figure is congruent with the national average. A higher proportion of Canberra males (47%) identified as carers in comparison with national figures (44%). There are gendered differences, however, in the pattern of caring: 83% of females and 17% of males identified themselves as primary carers, and male carers are more likely to provide care to a partner while female carers are more likely to provide care to a child or a parent (DDHCS 2003).

Access to mental health carers was negotiated after I had established a field presence in the community through the snowballing effects of attending meetings and public fora. In general, carers were interested in becoming research participants because this gave them an opportunity to have their experiences formally acknowledged and written up. Some carers regarded me as a potential instrument for promoting the carer's perspective while others were just glad to have a sympathetic ear, someone who was interested in listening to their stories and struggles.

The role of the researcher is imbued with more authority and knowledge by the community of research than is probably warranted. Since leaving the field I have been consulted by distraught carers seeking my advice on how to negotiate the 'psychedelic labyrinth' of Community Care. I am disconcerted by this view of me as a university 'expert' or 'knower'. My research stance has been informed by a feminist position that questions the dynamics of the relationship between the 'knower' and the 'known' and the myth of objective, neutral research. This stance was reinforced by undertaking fieldwork in a moral environment that demanded an engaged form of participation. Members of the mental health community are involved in a discourse of creating 'better' governance and policy solutions that is framed within a paradigm of community participation. While I originally negotiated a form of access that emphasised observation over participation, it became obvious that this position could not be sustained in a governmental setting dependent on the goodwill and efforts of overworked volunteers and underpaid workers: recourse to an 'observer' status was not a viable option and could have undermined my field presence. In the course of fieldwork I became an involved and engaged researcher. As a mother of five children, I also developed an admiration for the courage, strength and humour displayed by the carers of adult children.

The Canberra Schizophrenia Fellowship[126] provided the main source of carer interview participants. The Fellowship is a non-government organisation that provides information, referral and support services for carers as well as consumers. It has a membership of approximately 150, comprising individuals and organisations. Support groups such as the Fellowship not only represent a

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[126] Subsequently renamed the Mental Illness Fellowship of the ACT in 2006.

repository of knowledge but also provide a means for ‘telling the story’ and comparing one’s story with those of other carers in an understanding environment.[127] The Fellowship’s most active members are parents of adult children living with schizophrenia. In addition to providing support for carers, the Fellowship runs Canberra’s only funded vocational rehabilitation program for persons with severe mental illness. Voluntary board members lobby government and are also consulted by government to provide feedback on policy proposals. The Fellowship runs a telephone support service, conducts fundraising and mental health promotion activities, and works closely with psychiatric facilities, providing them with clothing, cigarettes, small amounts of cash and personal effects for patients with the donations received from pharmaceutical companies.[128]

I advertised for research participants through the Fellowship’s monthly Newsletter. Eleven of the fifteen carers I interviewed were in the 50-75 years age bracket.[129] Thirteen carers were women. All interview participants, to varying degrees and in various ways, have taken on the long-term responsibility of caring for seriously and/or chronically unwell family members, including providing them with emotional, social, financial and practical support. Most of the carers have, at times, also requested formal disciplinary action against family members who they believe are at risk to themselves or others.[130]

Eleven interview participants were carers of adult children, three cared for their partners, and one participant cared for a relative by marriage. The perspective of carers of adult children therefore informs this chapter. Only one carer of an adult child cohabited with that child. The remaining adult children lived in public, community and private housing. One adult child was subject to a community treatment and care order and resided at the Brian Hennessy Rehabilitation Centre at the time of interview with their parent. Four carers identified themselves as consumers and two identified themselves as ‘secondary consumers’, that is, they have developed anxiety and depressive disorders as a

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[127] See, for example, Pejlert (2001), Milliken (2001), and Opie (2001:171-173).

[128] This includes the purchase of feminine care products. At the time of fieldwork PSU provided wound pads for menstruating female patients. As consumer and carer interviewees pointed out, admission to PSU is usually a highly stressful experience and most consumers do not have the luxury of time or the capacity to prepare a toiletries bag or pack appropriate clothing.

[129] The carers I interviewed represent an articulate and knowledge group of participants in the mental health community sector. I make no claim that their views are representative of the experiences of all carers.

[130] A formal disciplinary response is usually initiated by legal application through the Mental Health Tribunal or by phone calls to the police or the mental health crisis team, with a view of having the consumer compulsorily detained or treated.

consequence of their role as carers. The older carers were aware that, with increasing age, their caring role would become diminished by illness and/or infirmity and expressed the concern that when they die, there will be no one to replace them as carers. One carer has passed away subsequent to my period of research in the field.

Training the Carer

Writing from the perspective of the late 1980s, Horsfall notes that families – or carers – 'are expected to become patient managers as psychiatric nurses had been a few decades ago – but without information, education, training, appropriate facilities, prompt access to a doctor or being able to leave the situation at the end of a shift (Horsfall 1987:534). While much of this situation remains true, subsequent to her writing carers have been provided with greater opportunities for becoming informed, educated and trained. In a formal institutional setting, the in-depth knowledge and skills gained by carers in mental health literacy training programs and in their daily roles and responsibilities would be equated with professional knowledge (Opie 1992:95).

In the policy language of Community Care, becoming more efficient in and taking on more responsibility for care has been equated with empowerment, with a shift from 'compliance' to 'partnership' (DDHCS 2003:8). The decision to take on the role of carer is followed by various processes of building mental health literacy through research and training, getting to know and to negotiate *the system*, and developing greater self-confidence in interactions with mental health professionals. Henderson and Forbat write that carers have been 'engaged as "relays" of the medical gaze in overseeing the health of those around them' (Henderson and Forbat 2002:671). Their governmentality perspective is in accordance with Rose's writings on the extension of psychiatric scrutiny in the community. In practice, the carer role extends beyond this narrow, governmental function, for the act of care takes place in complex and dynamic social contexts.

Federal and local governments have recognised the need to provide skills and literacy training for carers. Carers ACT is an organisational arm of the national body Carers Australia. It is funded by government to provide counselling and to facilitate regular get-togethers for carers. Carers are encouraged to undertake training courses on how to become more skilful at caring. To supplement their knowledge base, carers may access a library in addition to resources available for purchase. Carers ACT also runs a Carers Education Program, an outreach initiative targeting the ‘hidden carer’ and the ‘isolated’ carer, that is, ‘those carers that do not self identify as carers or who are not recognised as carers by professionals and/or the community’ (DDHCS 2003:6).

One of the implications of the policy figure of the carer is that it places care central to a relationship when, ‘(f)or many people, the central component of their relationship is not care, but interpersonal dynamics’ (Henderson and Forbat 2002:677). The carer construct tends to privilege a formal, quasi-professional role over an interpersonal relationship, resulting in what Henderson and Forbat refer to the ‘increasing professionalisation of informal care’ (Henderson and Forbat 2002:671).

Some people may be more comfortable in viewing their caring role in the context of interpersonal relations of which caring forms only a small part. Hidden and isolated carers are more likely to be men or those persons who come from a non-English speaking background. Men have not been traditionally viewed as carers and may therefore be reluctant to identify as such, while service providers may also overlook the caring roles undertaken by men. The Carers Education Program supports persons from culturally and linguistically diverse backgrounds by providing opportunities for social get-togethers and outings that are culturally appropriate to each of the fifteen different community groups it has targeted. One of the aims of these informal gatherings is to increase individuals’ awareness of how their familial duties and responsibilities may be incorporated within the language of care, including the role of carer.

Most of the carers I interviewed emphasised the importance of knowing how *the system* works. While effective medication for people diagnosed with a mental illness is a primary consideration during a hospital stay, knowledge of services such as consumer support groups, rehabilitation and employment programs, accommodation facilities, the management of finances, and the workings of the Mental Health Tribunal are also important, particularly as they form part of the community setting in which the psychiatrically dis-ordered reside. Knowledge of how to access the plethora of organisations in Canberra and the services they provide is not readily available to newcomers to the scene. I was told of a recent inquiry to the Canberra Schizophrenia Fellowship from a woman who is caring for a younger brother diagnosed with schizophrenia. His sister was at a loss to know what to do with him during the day while she was at work and had not been provided with information on the range of community services and activities for consumers.

Although the role of the carer has been recognised by government and carer organisations have been established to address their needs and concerns, the caring role remains largely informal and unregulated by virtue of its embeddedness in the private world of the family and/or household. Carers are more likely to rely on strategies evolved in the context of these interpersonal dynamics rather than on the arts of care promoted in policy discourse. Carers may have developed formally recognised skills of caring but these skills are mediated by the variable norms of the social setting in which they are deployed. Not surprisingly, carers - whether out of protectiveness for the relative or the family's reputation, or a clash between the values of the care-giver and the care-recipient - are more likely to favour a care mode reminiscent of the paternalism of the asylum era. That is, these carers, as a consequence of their personal investment in the care-recipient, are more likely to regard the psychiatrically dis-ordered as an untrustworthy and irresponsible child in need of repressive care.

The dynamics of care

In contrast to the language of Community Care which 'makes up' the psychiatrically dis-ordered as adult, self-responsible mental health consumers, carers are more likely to describe their unwell family members as weird, irresponsible, uncooperative, recalcitrant, vulnerable and dependent *children.* Similarly, in her study in Sweden, Peljert found that '(p)arents still perceived the adult son or daughter as a child from emotional age, which is quite understandable as the illness often interrupted the separation from parents' (Peljert 2001:201). Carers' solutions to symptoms of troubled and troublesome behaviour are more reminiscent of the paternalistic technologies of the asylum. Their strategies for dealing with recalcitrant adult children may therefore contradict the facilitative discourse underpinning the formal policies of Community Care.

Not surprisingly, these dynamics may manifest into a divergence between the priorities of carers and the care-recipients. As noted in Chapter 8, the relationship between families and their unwell relatives was at times fraught with tensions relating to the potential and real exercise of family control, including the threat of requesting their placement in psychiatric facilities. These tensions may be exacerbated when a parent is providing care for an adult child. Existing parent-child dynamics may be extended and expanded upon by mobilising a language of care, duty, safety and risk. Out of fears for and protectiveness of their children, coupled with their intermittent need for respite, carers tend to advocate for *tough love* solutions and the need for a *commonsense* approach. These include an array of disciplinary techniques, the main recommendation being an expansion of the forms of surveillance of mentally unwell persons in both institutional and community settings. For example, in response to a draft policy paper prepared by the ACT Health Authority in 1986, the President of the Canberra Schizophrenia Fellowship replied that, ‘to reduce manipulation we suggest that a firm and “contractual” approach be taken with patients where possible’.[131] There needs to be acknowledged, then, the possibility that some parents have used the psychiatric dis-order of their children as a way in which to respond to behaviour that they regard as morally unacceptable, through mechanisms of control or ostracism.

In public meetings, carers have been vocal in their support for institutional mechanisms such as *secure care* and *time-out* facilities. A common theme raised by carers is the difficulties and worries they face in managing unruly and disruptive adult children. In an interview, Pamela described her son as *uncooperative* and *unreliabl*e, someone who does not want to be regimented. He was also described as *anti-social* and *paranoid* around people. Pamela believes that the concepts of reintegration and rehabilitation, cornerstones of community care, were not helpful in the case of her son, who lives with a severe and chronic mental illness. Instead, he required consistent and constant support and surveillance.

Pamela’s concerns are shared by other carers of adult children. A study by Tuck, du Mont, Evans and Shupe provides further illustration of these concerns. The authors suggest that the tiring and unceasing aspect of caring for a seriously mentally unwell person contributes to building up the tensions between parental protectiveness and their respect for the freedoms and rights of the psychiatrically dis-ordered. Parents’ respect for the autonomy of their unwell children is diminished by acts of caring that are informed by:

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[131] Excerpt of letter from the President of the Canberra Schizophrenia Fellowship to the Acting Assistant General Manager of the Community Health Services Division, ACT Health Authority, dated 6 August 1986.

> constant background anxiety about the child. The parent cannot depend on the person with schizophrenia to make reasonable decisions. An important dimension of caring for the adult child with schizophrenia encompasses activities aimed at monitoring the day to day activities of the adult child so as to protect him from harm (Tuck *et al* 1997:123).

Several families expressed the view that consumers' freedoms in the community have become privileged over a *duty of care*. By duty of care they mean not only the safety and well-being of the consumer but also that of the family and the community. Several of the adult male children have physically assaulted their carers while some carers have been threatened with violence or subjected to other forms of abuse. Others spoke of the difficulties of dealing with children who, in addition to their psychiatric dis-order, also have alcohol and drug issues. In both interviews and participant observation exercises, a protective and disciplinary care model emerged as the preferred approach of families with psychiatrically dis-ordered adult children. Based on data generated by fieldwork, I would suggest that it is precisely this protective and disciplinary approach, combined with parents' expectations of children conforming to their standards of behaviour, and children's expectations of parents to provide and to accede to their demands, that shapes the dynamics of this potentially volatile care relationship. For example, during interviews, several carers described how they had been threatened with assault if they refused to provide their children with money for drugs. And several consumers talked about being ostracised by their families for not conforming to parental expectations.[132]

Concerns expressed by some families, that consumers' freedoms in the community have become privileged over a duty of care, were accompanied by the belief that the expansion of consumers' rights has been accompanied by a decline in families' influence over the lives of unwell relatives and in their interactions with mental health professionals. While policy makers recognise the contributions played by carers as well as the 'burden' they carry in caring for unwell family members they tend to overlook the role of carers' 'partnerships' with mental health professionals. These partnerships are at times fraught with

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[132] While I did not come across accounts of carer violence towards care recipients, in the interests of presenting another perspective, I would like to draw the reader's attention to Opie's account of carers of aged parents, who expressed 'frustration at their untidy appearance, and fluctuating ability to dress themselves ... it was not surprising that a number of carers spoke of moments of rage, of shouting, and of times when they had felt like hitting, or had hit their relatives.' (Opie 1992:98)

tensions, not least because of the disjunction between the different modes of care adopted by each ‘partner’.

The agency and responsibilities attributed to the policy figure of the carer and the policy rhetoric of partnership with staff[133] do not accord with the treatment of carers by mental health professionals. Despite their skills and their knowledge of the consumer’s background and history, most carers I spoke to believe they are not acknowledged or valued by mental health workers. Many expressed the concern that, while they have taken on the responsibility for providing the bulk of care for the unwell family member, they are not listened to by government or kept informed of their family member’s progress by mental health workers and, when it comes to discharge processes, that their views are disregarded by staff.

A contributing factor of the fraught relationship between families and mental health workers may be related to clinicians’ dependency on pharmaceutical solutions as well as the institutional environments in which they operate. Sophia believed that her knowledge of the factors leading to her daughter’s psychological deterioration was not valued and that the treating psychiatrist was more focused on compatibility and compliancy with a prescribing regime that was geared to containing and controlling for risk. In a study of the experiences of Swedish carers, similar concerns were voiced regarding parents’ interactions with mental health professionals. Pejlert describes Swedish parents’ reactions to being ‘excluded from the treatment of the family member’ and suggests that the ‘lack of cooperation between parents and nurses might be a lack of resources and increased workloads, with priority given to the care of the client, or as a problem of confidentiality’ (Pejlert 2001:201). In her research with mothers caring for adult children with schizophrenia, Milliken writes that ‘many feel that no one really listens to them, despite the fact that parents are the ones who provide the 24-hour care’ (Milliken 2001:1530).

Although deinstitutionalisation has outsourced responsibilities for care onto the carer, the development of market-place relations between the mental health provider and the consumer of mental health services tends to exclude and erode the carer’s voice and input. In contrast to the care arrangements mobilised by asylum authorities, the doctor/patient relationship in the community setting has been relocated within a purchaser/provider model: mental health service providers

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[133] See, for example, DDHCS 2003.

are now in an exclusive relationship with the purchaser or, more appropriately, user, of services. For example, permission for treatment procedures such as electro-convulsive therapy, formerly requested from the family, now requires the informed consent of either the consumer or, in the case of involuntary treatments, approval by a mental health tribunal.

In the Community Care setting, communications between the hospital and the carers are minimal because once consumers turn 18 they are regarded as adults, with rights to privacy and confidentiality. This move in part represents a formal legislative response to some of the systemic human rights abuses experienced by mentally unwell persons. As suggested in the previous chapter, the recasting of the mad subject as self-responsible and self-governing adult also represents a governmental concern with the cost effectiveness of health and welfare services. Arising then, out of a complex amalgam of consumer rights and neoliberal policy discourses, governmental arrangements emphasise the autonomy and independence of consumers. Mental health staff may not disclose personal information without consent from their client. The formal shift in the subject status of the psychiatrically dis-ordered has 'disenfranchised' the voice of the family and/or carer though this disenfranchisement is resisted, and the forums for carers to speak are becoming increasingly formalised and 'enfranchised' the consumer of mental health services. The disenfranchisement of carers is experienced by them as having 'little input into decisions about the care of their adult children, whom they see as being unable to care adequately for themselves or to make decisions in their own best interest' and to a perceived lack of 'rights and responsibilities that they believe are necessary to care for their ill adult children' (Milliken 2001:150).

While carers agreed that this governmental shift represents a move in the right direction, they also believed that in practice, its logic sometimes defied basic commonsense. Unless requested to the contrary by the consumer, carers are not notified when members of their family are admitted or discharged or when they abscond from psychiatric facilities. For example, a community worker related the story of a consumer who turned up voluntarily at a psychiatric facility. This person was not admitted but was given a drug and sent out before its effects had taken place. The person's carer was not informed. Another incident referred to was when a person was admitted to a psychiatric facility with psychosis. Due to staff shortages, the person was discharged despite the parents' protestations. The person ended up stealing the parents' car and at the time of the interview had not been heard from for over half a year. Sophia is still upset with the treatment she received from hospital staff whose response to her concerns regarding her daughter's progress was, *she's 18 – it's not your business*.[134] None of the staff were prepared to provide Sophia with any information relating to Marie's condition, apart from making the comment, *she's psychotic*.

Privileging consumers' rights to privacy and confidentiality may not only add to the worries experienced by carers. By excluding the voice of close family members, it may directly affect the efficacy of treatment regimes. In contrast to the current procedures of psychiatric facilities, Sandra believes that when a person is admitted with *the very first episode that they've ever had, and they've never had any other case of mental illness ... reported before, then it's imperative that the family be talked to, that that history is gathered rather than ... a family being just, you know, like totally cut off, from ... giving information or even receiving any information about their loved one.*

Current procedures privilege the consumer's voice over concerns expressed by the family. At times, this may have adverse effects for the consumer as well as for the carer. Carol told me of her family's experience with the mental health crisis team. Her adult son was making threats of violence against his father. Upon the Team's arrival, the son presented well and the parents were told to *stop picking on* and to *stop nagging* their son.[135] When he was finally admitted into a psychiatric facility, his condition had deteriorated to such a degree that he required several months' hospitalisation. Several years later, her son stopped taking his medication and started exhibiting signs of schizophrenia. While he was *still soft enough to see a doctor* she phoned to make an appointment but was told that her son would have to wait for two weeks. By then, Carol's son had *got hard* and was less amenable to psychiatric intervention. Eventually, Carol called the Crisis Team again. When they arrived, her son was sitting outside, clapping his hands together. However, he could still pull himself together in front of mental

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[134] It is not, therefore, surprising to find that in the Swedish study undertaken by Pejlert, the 'defence of the clients' autonomy and integrity in care emerged ... as some kind of red rag to the parents' (Pejlert 2001:201). Conversely, 'Nursing is built on trust in the client-nurse relationship, and the protection of client confidentiality in conflicts between the clients' rights and the needs of the families raise difficult issues for professionals' (Pejlert 2001:202).

[135] In his study with 34 families based in London, UK, Jones found that 'it was clear that relationships and communication between families and professionals were often very poor. Family members often felt that professionals were distinctly hostile towards them ...' (Jones 2002[b]:257).

health workers and they decided that he was *not sick enough* to be admitted to hospital. Carol was upset that her son was believed and that her own views were discounted. She was also upset that while her efforts in seeking psychiatric help for son ultimately resulted in his being placed on a community order, he refused to talk to her for three months.

The 'burden' of care

WHO Fact Sheets differentiate between the 'undefined and hidden' burdens of mental illness. These burdens are mainly connected by WHO to economic productivity levels and financial costs but they are also related to the effects of stigma and human rights abuses experienced by the psychiatrically dis-ordered.[136] The term 'burden' pervades the literature of madness, crossing boundaries of time and disciplines of knowledge. Care is consistently viewed as a burden for the care-giver, entailing isolation and stress, placing 'a strain on carers' health' and reducing 'their sense of well-being' (Opie 1992:189). The following excerpt from Henderson and Forbat exemplifies much of the literature on the caring experience:

> The carer is seen to provide whatever is needed, often at great personal sacrifice and cost, and bears a heavy burden (Henderson and Forbat 2002:671).

Mental health carers may be differentiated from other carers because the recipient of care follows an uncertain and fluctuating trajectory of diagnosis and possible rediagnosis, variable insights into and acceptance of their psychiatric dis-order, and episodic recurrences. Most of the interviews I conducted with carers commenced with their recall of the harrowing period during which they came to realise that their child was not exhibiting normal teenage behaviour but the symptoms of mental illness. They spoke of pathways to receiving care and treatment for their family members, in either hospital or custodial settings, of their interactions with staff, and the strategies they developed to *manage* unwell relatives.

In interviews, a common theme amongst carers was their children's deterioration. Issues of diagnosis and prognosis were raised as were factors they believed were instrumental in the aetiology of psychiatric dis-order. Most common was the role of cannabis use among their teenage children. Parents blamed their children's dope smoking habits as a contributive factor to the onset of psychosis, a typical comment being that dope *probably sent him over the*

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[136] http://www.who.int/inf-fs/en/fact218.html, accessed June 2004.

edge.[137] Parents believed that their children's persistence in *self-medicating* with marijuana also contributed to the frequency of their psychotic episodes and subsequent biological and social deterioration. One mother described the *burn out* effect, which she believes is so great that people diagnosed with schizophrenia never have a chance to emotionally mature and intellectually develop and, consequently, *they're always going to be weird.* Other causal factors were *personality* and family upheavals. Genetic influences were cited by only family.

Rosemary is one of several volunteers for the Canberra Schizophrenia Fellowship phone-line. She has empathy and understanding for her callers and often thinks: *you poor people,* for *they don't know what's ahead of them. You don't tell them, of course.* After 20 years of experience in the mental health sector, Rosemary believes that schizophrenia *breaks up families,* and that it is usually the mothers who are left to do the caring.

In their study of nine North American parents caring for adult children with schizophrenia, Tuck *et al* describe the 'essence' of the 'endless caring' experience as follows:

> Active parenting becomes unending. There is a struggle to reframe events as normal, to maintain some level of hopefulness despite an unanticipated and undesired transformation of the loved child. Knowledge about the disease (help from expert sources) and empathetic understanding of the experience (help from those who have lived it) are sought. Watching, protecting, seeking help, and sacrificing goals become daily activities that consume resources and challenge self-identity. Caring is embedded in the struggle to remain lovingly connected to this child while coming to terms with loss, gathering the meaning of the experience, and seeking to separate and preserve the self (Tuck *et al* 1997:123).

Taking on the role of carer, then, may come at huge social and economic costs to the person involved. It may also come at a physical cost. For example, research indicates that being a carer 'may accelerate risk of a host of age-related diseases by prematurely aging the immune response' (Kiecolt-Glaser, Preacher, MacCallum, Atkinson, Malarkey, and Glaser 2003:9095).[138] I was given access by one carer to a psychologist's report regarding the impact of long-term caring on this person's health and well-being: 'fearfulness, loss of appetite, loss of

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[137] Their views are backed up by demographic data for admissions to PSU in 2002-03, and this is discussed in greater detail in Chapter 11.

[138] In her study of 29 carers in British Columbia, Milliken writes that the 'burden of caring for an individual with schizophrenia produces psychiatric problems, sleep disorders, and physical illnesses in other family members' (Milliken 2001:161). She notes that the BC Task Force of Families of People with Mental Illness recorded that respondents to a questionnaire believed that their mental health (99%) and physical health (75%) had been negatively affected by having a family member with mental illness (2001:162). In her description of the interactions between 'families and their schizophrenic offspring', Horsfall writes rather bluntly that 'each makes the other feel worse' (Horsfall 1992:535).

stamina and interest, pervading feelings of hopelessness and despair, social withdrawal, and strained relationships; anxiety and depression; trauma.' This carer has subsequently passed away.

The guilt, shame and stigma of care

Despite the recognised burden of caring, the shift in responsibility, from government to carer has been achieved not only because of the love and sense of duty family members may feel towards their relatives but also because carers may feel a strong sense of guilt and responsibility for the psychiatric dis-order of their family member. Not surprisingly, many carers feel not only the burden of care, but continue to feel the burden of guilt for their potential role in causing or exacerbating a relative's psychiatric dis-order. While carers did not directly attribute their parenting style with the onset of their children's psychiatric dis-order, like the carers of Milliken's study they did accept that they were susceptible to community blame and also acknowledged feeling guilty, for not seeking treatment at an earlier stage, for not caring enough, for a lack of patience and understanding, and for making applications that the family member be involuntarily hospitalised and/or treated (Milliken 2001:160). Intertwined throughout these feelings of guilt is stigma:

> (p)arents also experience the stigma ... of mental illness when either professionals or lay persons blame them for their child's illness. In the absence of blame, parents still may experience a "courtesy stigma", ... the spoiled identity conferred upon those who associate with people who are stigmatised. Totally occupied with caring for their child, some parents avoid their friends. In other cases, their friends are uneasy with mental illness and may avoid the parents (Milliken 2001:152-3).

When Jonathon was diagnosed with schizophrenia, his parents were told by members of their church that his psychiatric dis-order was their fault and they subsequently faced community ostracism. At the time, they were given no support or information from health professionals. The belief that it must be the parents' fault put a huge strain on the marriage: each partner blamed the other for Jonathon's psychiatric dis-order. The marriage did not survive.

Kate described watching her children become unwell and feeling helpless to do anything about it. The constant worry about their welfare has negatively impacted on her health: Kate suffers from an anxiety condition. Her marriage ended and she now faces her responsibilities as a parent on her own, accompanied by strong feelings of remorse and guilt: *I must be a hopeless mother*.

Lily described the guilt she felt in making an application for her son to be involuntarily treated. Her son found out and phoned her up, shouting *How dare you put me away! ... you're going to lock me up! I hate you! I'm going to kill you!*'

> *Of course, I got scared stiff and immediately rang my* [family member] *at work and he left work and came home and went straight around to* [Jake's] *place and of course* [Jake] *was in a terrible state. Dreadful! He was so mad, because he thought he was going to be put into an institution ... he doesn't realise that there aren't any institutions anymore, but anyway, he couldn't understand why. And of course, he'd read what we'd written! And that hurt him terribly.*

Rosemary also described the guilt she felt in making an application for her son to be involuntarily detained and treated and was present when several police officers 'escorted' him to the psychiatric ward. She had noticed a deterioration in her son's living skills and suspected he had stopped taking his medication. Rosemary took photos of the living conditions in her son's unit to prove before the court that he was having a *social breakdown*. Throughout the process, she *felt like a rat* and understands why her son was upset and hostile towards his mother: *you embarrass them publicly*.

Policy rhetoric aside, the shaping or making up of the carer may also be understood as a personal and private experience of becoming marginalised and stigmatised. The community continues to respond to severe and chronic forms of psychiatric dis-order with awkwardness, ignorance and fear.[139] One of the reasons why carers join support groups may be as a direct response to this process of stigmatisation and social exclusion. Milliken writes that one of the benefits of support groups (such as the Canberra Schizophrenia Fellowship) is the opportunity for families to develop a form of:

> "parental suffrage" .... played out through taking on the "system". Parents engage in volunteer work, advocating for the mentally ill and improving public education and public knowledge about schizophrenia. (Milliken 2001:153)

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This chapter traced the experiences of carers in the Community Care era. It explored some of the dynamics of the relationship between carers with agents of

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[139] See, for example, J C Phelan, E J Bromet and B G Link, Psychiatric illness and family stigma, *Schizophrenia Bulletin* 24 (1), 1998; Katarina Stengler-Wenzke, Johanna Trosbach, Sandra Dietrich, and Matthias C Angermeyer, Experience of Stigmatization by Relatives of Patients with Obsessive Compulsive Disorder, *Archives of Psychiatric Nursing* XVIII (3), 2004.

government and the psychiatrically dis-ordered. I considered families' experiences of guilt, shame and stigma and the 'burden' of care.

It would be simplistic to view the carers of my study as agents operating in 'relays' of the medical gaze or conversely, as authoritarians out of step with the facilitative intents of Community Care, for their role encompasses more than that prescribed within mental health policy discourse. The role of the carer is embedded in interpersonal dynamics that may encompass and at times come into conflict with other roles such as that represented by the parent who has been left with the responsibility for risk management of a mentally unwell person. Contrary to the facilitative and enabling language of Community Care, the roles and responsibilities of such carers are also framed in a language of protectiveness and concern for a vulnerable child, well after that child has turned 18. In the next section, the dynamics of care are examined from the perspective of 'cultural Others', by exploring why they have been deemed in need of care. Section 4 also considers how each care regime has given rise to new forms of possibilities of action for the subject and object of care.

SECTION IV

SUBJECTS OF CARE

The previous Section examined some of the relations of care in each of the care regimes. The chapters explored the different ways in which the arts of care have been mobilised by nurses and families. The metaphor of family was evoked to describe an institution of dysfunctional behaviour or alternatively, a place of belonging. Herd Care was imagined as an authoritarian family formation while Therapeutic Community introduced permissive arts of care into the asylum. Each chapter narrated the themes of stigma, shame, grief and the burden of care from the perspective of care givers.

Section IV examines why Kenmore inmates and Canberra consumers have been deemed in need of care. It describes the *multicultural* residents of the asylum and the mental health consumers of Canberra, including the symptoms of psychopathology that set them apart as transgressors of culture. This Section also explores the new possibilities for action that have emerged in Australian twentieth-century mental health governance, when the psychiatrically dis-ordered have been encouraged to learn how to be free. I illustrate how freedom has been differentially articulated in each care regime. At the same time, I note that discrepancies within and overlaps across each care regime may be attributed to the capacities for autonomy of the subject of care.

11. The Cultural Others of Kenmore and Canberra

> He is an inadequate psychopath who has made a nuisance of himself in the community by attempting to commit suicide in an inadequate manner

The above comment was entered into Kenmore's Medical Journal during the 1950s. The man, who I refer to as Jim, gained notoriety because he had escaped from the asylum and tried to commit suicide. Jim was subsequently recaptured and returned to Kenmore. The language used to describe him as 'inadequate' and as a 'nuisance' suggests that the author was annoyed by his behaviour and had little empathy for the reasons leading up to his escape and 'inadequate' suicide attempt. No doubt Jim had created additional work for staff through an obligatory search operation, and had perhaps also caused the asylum some public embarrassment regarding the adequacy or otherwise of its systems of surveillance and care. Jim had been sentenced to Kenmore Hospital as an inebriate through the powers vested in the NSW *Inebriates Act* 1912. While the terms used to describe Jim may have had some clinical relevance during the period he was incarcerated at Kenmore, I would suggest that the Medical Journal entry equally evokes the author's exasperation with and moral evaluation of Jim's behaviour.

The use of the language of psychopathology by asylum staff to disparage and discredit residents as well as members of the outside community who they found disagreeable was evident in Kenmore's documented history, including its medical records. One explanation for this practice is to regard it as a cultural phenomenon reflective of insider knowledge and work practice. The psychopathologisation of certain behaviours reveals a flexibility of meaning and application. Describing Jim as an inadequate psychopath may therefore be regarded as an explanation both for why he had breached asylum rules, by attempting to escape, and why he had breached the norms of moral propriety, by attempting to commit suicide. Finally, the psychiatrisation of Jim's behaviour also symbolises the stigma and polluting qualities associated with psychiatric dis-order: by virtue of his involuntary co-habitation with the mad, Jim's actions were interpreted within a psychiatric framework.

This chapter describes the signs of pathology and dis-order that marked the residents of Kenmore and the consumers of Canberra in need of care. Drawing on the cultural narrative of psychiatric primitivism, I examine how contraventions against dominant norms of rationality, industry, and progress marked them as cultural Others. The chapter follows a chronological trajectory, from asylum to community, and draws on aggregate data for Kenmore inmates and the patients of Canberra's PSU as well as data generated through group discussions and interviews with former Kenmore nurses and mental health consumers.

A 'multicultural' institution of degenerates

In his seminal work, Scull describes asylums as:

> museums for the collection of the unwanted … a dumping ground for a heterogeneous mass of physical and mental wrecks – epileptics, tertiary syphilitics, consumptives in the throes of terminal delirium, cases of organic brain damage, diabetics, victims of lead poisoning, the malnourished, the simple-minded, and those who had simply given up the struggle for existence. (Scull 1979:251-2)

In a group discussion with former psychiatric nurses at the Kenmore Hospital Museum, Linda described the asylum as a *multicultural institution: we looked after inebriates, we looked after psychotic people, young and old, we looked after geriatrics, we looked after retards.* Kenmore also had wards set aside for persons described as *epileptics* and from the 1930s onwards, provided care and treatment for inebriates. It was indeed a *multicultural* institution, its residents' individual differences united by their defective otherness.[140] This was despite the outspoken criticisms voiced by various incarnations of Inspector-General of Mental Hospitals in their annual reports to the NSW Legislative Assembly, that the aged and infirm, the epileptics, the retards and the inebriates be housed in separate institutions and provided with specialised care. The asylum continued to remain a holding institution for *multicultural* degenerates.

While NSW psychiatry argued that these *multicultural* constituents be divided up and separated out into specialised institutions, the rationale for *lumping* them together continued to be favoured by government due to the cost-effectiveness of this solution. Significantly, one legal instrument for admission, care, control and discharge was used for most categories of inmates. Until the late 1950s, with the exception of inebriates, who were governed by the *Inebriates Act* 1912, admissions to Kenmore were administered by the powers vested in the NSW *Lunacy Act* 1898.

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[140] 'Sheila', a psychiatric nurse, describes a key feature of nursing in an Australian asylum in the early 1970s as managing 'the large number of people brought in who don't belong here. Since I have been here it seems that most of my time is spent assessing elderly people who have no homes, or alcoholics who are put away by their families. As well, we have many intellectually handicapped people here, and because of lack of space, they are mixed in with all the others' (Gardner 1976:76).

Table 11.1 provides an overview of the 'multicultural' spread of Canberrans admitted to Kenmore during the period 1925-51.

Table 11.1. Canberra Inmates, 1925-51[141]

Category of Inmate	**F Nos.**	**F %**	**M Nos.**	**M %**	**M & F Total**	**M & F Total %**
Psychiatrically Dis-ordered	14	63%	20	42%	34	49%
Alcoholic	2	9%	11	23%	13	18%
Retarded	4	18%	6	12%	10	14%
Aged and Infirm	0	0%	7	14%	7	10%
General Paralysis of the Insane	1	4%	2	4%	3	4%
Epileptic	1	4%	1	2%	2	2%
TOTAL	**22**		**47**		**69**	

Epilepsy has historically been associated with madness. For example, similar to the folklore associated with lunatics, it was believed that a full moon could bring on an attack (Busia and Murphy 2005:35; Porter 1995[b]:169). Symbolising a form of degeneration, the epileptic has also been historically associated with sexual perversions such as masturbation, and a predisposition to criminal activity (Porter 1995b:170). In NSW, epileptics were confined in asylums alongside the insane and administered under the *Lunacy Act*. Despite their recommendations, representatives of NSW psychiatry were unsuccessful in bringing about 'specialised colonies' of care. Kenmore had special wards set aside for epileptics although it is quite likely, that as the asylum became increasingly overcrowded during the twentieth-century, this category of inmate would have shared the spaces of their ward with other residents. Two Canberrans were admitted as epileptics to Kenmore between 1925 and 1951.

The category of alcoholic does not refer to those persons admitted under the *Inebriates Act*. Persons with drinking problems were thus administered through either legal or psychiatric pathways. This created a dubious distinction whereby alcoholics could be certified as insane by asylum doctors as a result of their drinking habits, whereas inebriates were deemed by courts of law to be lacking in will or self-control rather than reason (Brown 1995:669). Inebriates were sentenced to the asylum to dry out for finite periods of three, six or twelve months whereas a discharge date was not determined for alcoholics certified as insane.

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[141] Denoting both the year that the first Canberra person was admitted to Kenmore and the period I had access to residents' medical records. The figures for Canberra Inebriates are not included in this table as I did not have access to their files. The names of a total of 21 Canberra inebriates were listed in an Inebriates Register for 1938-50.

Reflecting the different pieces of legislation that governed them, admissions of alcoholics were listed under the main administrative instrument and those of inebriates were entered under a separate register.

Inebriates were admitted to Kenmore under the *Inebriates Act* and individual entries were recorded in a separate register. The first Inebriates Register I was able to gain access to commenced in 1938. Due to their special status that set them apart from the other inmates, there were no files for inebriates in the ward that housed the medical records. Data on inebriates has therefore been obtained via the Medical Journal or from interviews and group discussions with former nurses.

One in four Canberra men were admitted for alcohol problems. The asylum was a place to dry out from alcoholic binges. Of these, many were returned soldiers, unemployed and/or of No Fixed Abode. For these men, Kenmore offered a temporary respite from their troubles in the form of food, accommodation and enforced rest and routine. Their stays were short, usually of several weeks' duration and, if they were formally admitted, it was more likely to be a voluntary admission. Eleven (23%) Canberra men were admitted to Kenmore during 1925-51 as voluntary patients in comparison with two (9%) women.

The 'aged and infirm patients of the chronic and harmless class' and 'harmless old persons suffering from senile decay' could be sent to the asylum and certified as insane.[142] Porter notes that increases in life expectancy resulted in the rise of age-related diseases among western populations (Porter 1995[a]:56). From the nineteenth-century onwards, asylums were increasingly regarded as institutional solutions for this growing population group. He writes that by the turn of the nineteenth century, asylums were filling up 'with a never-ending stream of apparently incurable and untreatable elderly demented patients' (Porter 1995[a]:59).

Old people who had become a burden on their families formed a sizeable part of the total figures for Canberra inmates. Seven (approximately 10%) of the 69 Canberra inmates were incarcerated under the *Lunacy Act* for problems relating to old age. All of the seven inmates were men. As an institution for *multicultural* degenerates, one could argue that Kenmore was a suitable placement as this category of inmate bore the physical and visible signs of the degenerative

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[142] Inspector General annual reports to the NSW Legislative Assembly, 1933-34 and 1938-39 respectively.

processes of ageing. Their transgression from the cultural norms of rationality, industriousness and autonomy was a natural part of ageing and generally, a permanent state of being until their death. Unlike the psychiatric inmates, then, recovery was not possible. For the majority of the aged and infirm, Kenmore was a final resting place while they waited to die.

In addition to the aged and the infirm, there was another category of inmate at Kenmore whose degeneracy was also regarded as a permanent state of being. This was the retard, embodiment of physical, moral, and mental degeneracy, for whom recovery was deemed limited or impossible. Locke's writings on idiots– 'brutes abstract not' – has depicted them as 'non-human animals' (Goodey 1995:245). At the same time as they advocated for infirmaries for the aged, different incarnations of Inspector Generals advocated for the separate housing of retards in 'specialised colonies'. Throughout the first half of the twentieth century, in annual reports submitted by Inspector-Generals, regular reference is made to the mentally defective, to the effect that, 'the segregation of this class is essential if the mental and physical standard of the race is to be maintained'. As discussed in Chapter 6, it was not until the 1980s, following the recommendations of the Richmond Report, the blueprint for deinstitutionalisation in New South Wales, that the Government physically separated psychiatric from retardation residents. Despite ongoing protestations by representatives of psychiatry and community, mentally defective inmates were administered by lunacy/mental health acts until more appropriate legal instruments, the *Disability Services and Guardianship (Provision of Services) Regulation 1989* and the NSW *Disability Services Act* 1993 were enacted in response to Richmond Report recommendations.

The following circular from the Inspector-General to Medical Superintendents (Figure 11.1) exemplifies psychiatry's concern with the signs of defective behaviour, and the role of classification as a managerial strategy.

Figure 11.1. Circular, NSW Inspector-General of Mental Hospitals to Medical Superintendents, 12 April 1926[143]

I would be glad if you would send me the names of all mentally defective patients in your Hospital, both male and female, giving their ages and address of relatives. I would be glad if you would classify these under the following four headings:

(a) High grade stable
(b) High grade unstable
(c) Low grade stable
(d) Low grade unstable.

In (a) the determining factor should be the mental condition, character of the patient and the amount of benefit to be derived from training. It is important to note that the license of parents in these cases does not always prove most successful, and that in the case of high grade unstable patients a return home usually means a return to the same surroundings and influence which were fatal before.

It is also to be remembered that good behaviour under sheltered conditions in an institution is little guarantee to behave while outside. This is specially the case of the high grade unstable girl without sexual control.

The capacity to do good industrial work in the workshop of the hospital does not indicate the capacity to compete with normal workers outside without special direction and supervision.

The term ‘High Grade’ means mentally defective persons whose intellectual incapacity does not prevent them becoming of some economic value to their families, though even in very rare cases self-supporting.

The term ‘Low Grade’ is used for persons inherently incapable through lack of intelligence of making any adequate contributions to the family expenses or of attaining independence.

The high grade unstable case though sometimes barely sub-normal intellectually may be debarred from independence by instability showing this in hysteria, violent temper, romancing, thieving, lack of sexual control or sexual perversion. The high grade stable cases show none of these actively unbalanced tendencies. As a group they are less intelligent than the high grade unstable cases. The wage earning capacity is counterbalanced by their defective behaviour, but their steadier conduct enables them under sheltered conditions to lead harmless useful lives. In the same way the low grade have to be divided into stable and unstable classes, the lethargic harmless idiots and imbeciles in the one and the restless and destructive in the other.

I would be glad if opposite each of these cases you would describe any offences of which they have been found guilty, and also the nature of the work which they are doing in the various hospitals at which they are located.

I would also be glad if you would set opposite them those you consider suitable for Milson Island, those you consider suitable for Stockton and those you consider suitable for Morisset.

The question of their being useful workers in their particular hospital should not be allowed to weigh in the matter at all.

It is desirable for purposes of scientific classification that mental defectives should no longer be classed unless absolutely unavoidable, amongst mental patients of a different type and it is also advisable and in conformity with modern methods that they should as far as possible be segregated altogether.

Efforts can then be made to train them manually and practically in a scientific manner, so that some of them may perhaps in the future be able to earn their living outside under supervision, besides having their liberty and perhaps relieving the State of the maintenance of the beds occupied by them.

CA Hogg
Inspector General

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[143] Circular No. 26/48, 1926, 5/5876-5877.

The circular seeks to gather information on levels of supervision and control required for mental defectives in NSW asylum populations and their capacity for training and re-integration in the community. Unstable high grade and low grade retards are described as a moral and physical danger to themselves and to the community; their control and containment within an ordered institutional environment deemed as the most appropriate treatment. In response to the Circular, Kenmore replied that:

> It is difficult to decide in some cases whether the patient is a mental defective or some form of Dementia Praecox and mistakes are bound to be made.[144]

One of the Canberra inmates admitted to Kenmore presented the asylum doctors with such a dilemma. Admitted as a mental defective, Judith Kirkpatrick was subsequently rediagnosed with schizophrenia (diagnostic successor of dementia praecox) during her 14 years' confinement in the asylum. Table 11.2 below lists the retardation inmates from Canberra who were sent to Kenmore 1925-51.

In common with other forms of degeneracy, the concept of retardation or mental defectiveness has slippery meanings, revealing more about the moral contexts in which it is spawned than about any claims to scientific, objective classification. The notes for Judith Kirkpatrick suggest she was regarded as a difficult woman because she contested both her father and the patriarchal authority of the asylum. Kirkpatrick attempted to escape from Kenmore on two occasions. Her refusal to take her medication by hiding her pills under her mattress is also recorded on her case notes.

Inappropriate sexual behaviour could be regarded as a sign of mental defectiveness. The promiscuousness of two female retards is noted on their files. Four male retards originating from Canberra were diagnosed as mentally deficient for transgressing sexual norms or laws. Of these, the families of two of the men purposefully chose Kenmore as a way of avoiding the embarrassment of facing a public trial. One of these men, Andrew Williams, an educated, wealthy man, is described by the asylum as a moral imbecile on account of his homosexuality and sexual interest in young boys. A diagnostic trend of linking inappropriate sexual behaviour with mental defectiveness was not unique to Kenmore. For example, based on his research at Toronto Hospital for the Insane, 1870-1940, Reaume found a relationship between promiscuous behaviour and the diagnosis of mental deficiency (Reaume 2000:31).

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[144] Letter dated 11 May 1926, correspondence files.

Table 11.2. Canberra Retardation Inmates 1925-51

Name	Diagnosis	Comments
Glenda Hackett	Congenital Mental Deficiency (CMD)	Had a baby that was put up for adoption after being 'jilted' by her boyfriend
Tim Hocking	Euphoric decontrolled high grade CMD	16 years old; history of indecent exposure; described as a masturbator Physical signs of sexual maturity were recorded in his case notes
Edith Hunter	CMD	'in constant moral danger if left to her own devices'; difficulty in 'controlling her sexual tendencies'
Ronald Jones	CMD	'idiot'; 'helpless imbecile'; 'dirty, dribbling imbecile'
Judith Kirkpatrick	CMD (rediagnosis of schizophrenia)	Father's comment: 'too much worry'. Kenmore's comments: 'mentally weak and physically retarded'; 'behaves like a spitting cat, aggressive and abusive and dramatical'; 'capricious'; 'impulsive'; 'PMT ... strong hysterical overlay'
Barry Lee	High class imbecile	'little idea of right or wrong', charged with attempted rape of a woman
David Maloney	Mentally defective	'sexually interfering with small girls'
Ruby Nelson	Low grade imbecile	'Many stigmata'; 'Borderline idiot'; 'Short. Mongoloid eyes, open mouth, vacuous expression'
Samuel Weatherby	CMD	'wears a silly inane grin and looks mentally weak'
Andrew Williams	CMD (Moral)	'moral imbecile'; homosexual; 'intercourse with boys, stealing'

The imagery of the throwback, reminiscent of the Barbarian primitive, was at times also present in Kenmore nurses' recollections of caring for retards. The following discussion between two nurses describes the challenges of caring for 'Eve' and 'Jane':

> *Brenda: Well, see,* [Eve] *could not sleep unless she had a straight jacket on, she was so depraved. She used to cover everything in shit. Oh God, it was dreadful.*
> *Linda: She was like an animal, and she had these horrible short little hands and short, stumpy fingers ...*

The conversation then turned to Jane:

> *Brenda: And oh God, it was like feeding a pig, honestly. You'd come in and you'd put her breakfast down here, and she'd stand up in the middle of the table and piddle like a horse ... she wasn't so fat but she was very big – not fat but solid sort of, heavy sort of a woman. And she'd stand up on the table, an oblong table with six people at it, and she'd just piddle like a horse, you know, open her legs out, shocking she was. ... and when she got her food ... she'd just get a handful and eat it, not use her utensils or anything.*

Discussion of retards invariably turned to incest, committed in isolated, rural areas where the defective progeny of families’ sinful behaviour could be hidden away, locked up in sheds. That is, until discovery by authorities and their forcible removal to the asylum:

> *Linda: they locked them in sheds … didn’t they?*
> *Brenda: Yeah, we had a group of people here that came from … The day they came in, there was a police truck … and it looked like a cage, and there were all these people in it, and they were all brothers and sisters …*
> *Linda: There might have only been the four.*
> *Brenda: And they were all in the back of this cage, and they let ‘em out to bring ‘em in, and you’ve never seen anything like them, you said “what the bloody hell!” …*
> *Linda: And she was a real animal, and her appearance and everything …*
> *Brenda: And they were all retarded, but they weren’t violent. They were just retarded.*
> *Linda: And, because they were interbred, they were all, apparently it had gone back for a few generations, it wasn’t just (the) one … it was doubtful whether some of their parents were their brothers or their sisters, or their sisters were their mothers or some bloody thing, you know.*
> *Brenda: All mixed up. …. You look at the places like … out here. They’re all interbred out there but then in those days you could understand why, too, because there was no transport. It’s right out in the bloody hills to buggery and they were all married to* [indecipherable] *bloody brothers.*
> *Linda: Oh well, you’ll find … any country area in Australia – it could be in the world – is, is fairly similar.*

Degenerate or desperate?

Case notes not only described inmates’ signs of cultural otherness but also chronicled the pathways that had brought them to the attention of asylum authorities. For some, the asylum provided sanctuary and retreat. As one nurse commented during an interview, *there was nowhere else for them*. Case notes for Canberra inmates reveal stories of people whose lives had been ruptured by the physical and mental traumas of war, the struggles of poverty, the dislocation of migration, the shame of motherhood without the societal sanction of marriage and the accompanying sadness of being forced into adoption procedures. These were the ‘mental shipwrecks’ (Ellery 1945, in Damousi 2001:134) for whom care in the Arcadian setting of the asylum was regarded as the appropriate solution.

The disparity between male and female numbers, as set out in Table 11.1 above, is reflective of Canberra’s demography at the time. Not surprisingly, the years immediately after World War II, when building and construction were on the rise, represented a period marked by a gender imbalance in the population.

The construction of Canberra required male labour.[145] At the same time, the Nation's Capital did not provide adequate accommodation for families. Married men tended to leave their families interstate or overseas until appropriate housing became available. The gender disparity was most pronounced in the figures for migrants; for example, by 1951, there were 1530 overseas born males living in Canberra in comparison with only 580 females (Borrie 1954:225). Overseas born migrants were more likely to live without family support networks than the Australian born. It comes as no surprise, firstly, that of the male inmates, 26 (55%) were single and secondly, that overseas born male migrants were overrepresented, with a total of 19 (approximately 40%). In contrast, and reflective of Canberra's demography, of the 22 female inmates there were only three overseas born migrants.

Many of these mental shipwrecks were melancholics responding to the societal stresses of war, unemployment or dislocation. Thomas Lyons, a homeless and penniless overseas born migrant who had fought in World War I, was escorted by Canberra police to Kenmore and discharged after two weeks. His notes state that he was a chronic alcoholic. Charles Jennings was also escorted to Kenmore by Canberra police. Initially, he was described as 'confused and suspicious'. After two weeks, he was formally admitted as a voluntary patient and commenced work in the Carpenter's Shop. After one month at Kenmore, Jennings' notes read: 'Asked to go and was discharged'. Kenneth Smith, unemployed of No Fixed Abode, was admitted to Kenmore for six months and then, four months after discharge, was re-admitted, this time for almost two years. He was described as depressed and alcoholic. Smith had seen military service 1914-18. On his second admission, he arrived from Goulburn District Hospital by ambulance, with '(t)wo self-inflicted wounds on right wrist, one on left wrist'. On his first admission to Kenmore, Smith was given the status of Privileged Patient, that is, freedom of the grounds. His treatment included work in Kenmore's orchards. Smith regained Privileged Patient status on his second visit – 'is trusted to get about the grounds by himself' - and was employed at the residence of the Medical Superintendent.

Canberra women were brought to Kenmore because they had become troublesome to their families and/or were incapable of looking after themselves or

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[145] In 1947, there were 116.37 males per 100 females in Canberra, in comparison with the national average of 100.41 males per 100 females (Commonwealth Bureau of Statistics 1947:53,56).

fulfilling their domestic responsibilities. Some of these women had transgressed the norms of middle-class femininity and as such, were regarded as a threat to themselves and/or represented a threat to the Canberra community. Victoria Brewer was described by her father as ‘obstinate and rather than follow any advice would prefer to take the opposite view’. In a letter from people she had boarded with for six weeks, it is stated that they ‘found her spirit of independence and self-reliance made cooperation difficult’. Autonomy, it appears, was a virtue only when it was embodied by men.

Historians of nineteenth and twentieth-century management of lunacy and mental illness have observed that signs of female insanity were more likely to be attributed by psychiatry to internal, biological factors while men were supposedly driven insane by external stressors (for example, Garton 1988:114,138 and Coleborne 1997:11). The incompleteness and inconsistency of Kenmore’s medical records and diagnostic terminology do not provide a database from which these observations may be tested. However, external stressors such as war, heavy drinking, transient lifestyles and disconnection from families were frequently noted on men’s files. It was also regarded as noteworthy to attribute biological factors on several women’s case notes. For example, Dawson’s psychiatric condition is explained by her ‘change of life’ issues; Best is described as ‘hysterical’, and Brewer’s menstrual cycle is connected to her erratic behaviour. According to the figures presented in Table 11.1, women were also more likely to be admitted to Kenmore for a psychiatric dis-order (63%F in comparison with 42%M).

Of the 22 Canberra females admitted to Kenmore during 1925-51, 12 were married, eight were single and two were widowed. In contrast, Canberra males tended to be single: of the 47 men, 26 were single, 15 were married, and six were widowed. The high number of single men is most likely a reflection of Canberra’s demography at the time. However, in her study of Toronto Hospital for the Insane during the nineteenth century, Mitchinson uncovered a similar gendered relationship between sex and marital status in asylum inmates. Mitchinson draws on the writings of Joseph Workman, Medical Superintendent at Toronto for much of the second half of that century. In 1859, Workman accounted for the prevalence of single men in the asylum by referring to their masturbatory habits. In 1862, Workman attributed women’s biological destiny - that is, childbirth - as a reason why married women outnumbered single women.

In 1872, he concluded that ‘as far as liability to insanity is concerned, marriage is very dangerous to women and single life very dangerous to men, whilst married men and single women enjoy comparative immunity’ (Mitchinson 1987:107). Sexual acts, it seems, were a cause of insanity in both men and women, but for different reasons.

While biology played a role in accounting for their insanity, women were also vulnerable to maddening societal pressures. Indeed, one could speculate that the living conditions for Canberra women in the first half of the twentieth century may have had a negative effect on their psychological well-being. Women may have struggled to raise their children in a ‘frontier’ community without established infrastructural and family supports. This was clearly evident for Margaret Black, whose case notes are discussed in greater detail in Chapter 8. For women of middle-class origins who accompanied their husbands, the Nation’s Capital was not necessarily a socially attractive destination:

> For the young, socially ambitious woman whose husband is a minor official, Canberra will be a very neat and complete hell. But for the wise young woman who is content to play with her children ... do her round of golf ... Canberra may be filled with light and cheerfulness and grace and peace within the border. (*Bulletin*, 25 November 1926, cited in Gibbney 1986)

Asylum to community: reflections from the field

Table 11.3 sets out the gender and self-identified psychiatric dis-orders of 22 Canberra mental health consumers who volunteered to participate in formal interviews.[146] Of these, five participated in a second interview, either at my request or at their instigation.[147] Research participants were men and women diagnosed with a serious and chronic psychiatric dis-order, the majority of who lived below the poverty line in public accommodation facilities and were reliant on government disability pensions. And it is their perspectives, that is, the lived experiences of the seriously and chronically unwell, which inform my analysis of the arts of Community Care.

Six of the 22 consumers had spent time in Kenmore from the 1960s onwards (the average was two periods of ‘hospitalisation’ in the asylum). All interviewees had experience of Canberra’s in-patient psychiatric facilities. While they identified themselves firstly as consumers, seven have also had the experience of

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[146] By advertisement, through a consumer newsletter and on a notice-board at a psychosocial rehabilitation centre.

[147] In addition to formal interviews, informal conversations and social encounters with consumers and other stakeholders in the mental health sector informed my fieldwork as a participant observer.

caring for someone with a psychiatric dis-order. Two of the consumers met one another in a psychiatric facility and have been in a relationship for almost twenty years.

Consumers were provided with $25 for each interview (of approximately an hour's duration). Several members of my supervisory panel questioned my reasons for insisting that consumers receive a payment, pointing out that I was not paying other research participants for their contribution and time. They also wondered whether the promise of payment would attract participants with little to contribute in terms of data quality. In contrast, I believed that a modest payment for consumers, the majority of who lived on a pension or benefit and had experienced stigmatisation and disenfranchisement from the *system*, their families and/or friends, was ethically appropriate. Mental Health ACT supported my view, and provided money for 20 interviews. The remaining seven interviews were subsidised by my university or out of my own pocket.

While it became obvious that the promise of $25 did attract several interview participants who were more interested in obtaining money for cigarettes than they were in contributing to my research, it also resulted in my having access to the stories of people who would not normally have come forward and offered their time. The offer of a payment, however small, was also a mark of respect and acknowledgement of their knowledge and experience. For the majority, this acknowledgement was also a novel counterpoint to their encounters with psy-professionals.

Table 11.3. Canberra Mental Health Consumer Research Participants, 2003-04

Diagnostic Category	Female	Male	TOTAL
Bipolar Dis-order	6	3	9
Schizophrenia	1	3	4
Depressive Dis-order	4	1	5
Not Provided	2	2	4
TOTAL	**13**	**9**	**22**

All consumers were invited to comment on their interview transcript(s) and, where necessary, make amendments or additions. Fifty percent (11) availed themselves of this opportunity. This process was fruitful in that it extended my dialogues with consumers.

When I set out to interview consumers, I was interested in discussing with them their experiences of care. Naively or foolishly, I consciously did not ask them to divulge their psychiatric diagnoses for at that stage I did not consider it valuable to accumulate such information. Related to this point, I did not wish to intrude into an area of controversy and dissent around the accuracy and value of psychiatric nosology. Apart from the key themes I had prepared in advance for each interview, I adopted an open-ended approach that provided opportunities for free-flowing conversation. Subsequently, I discovered that the majority of research participants wanted to talk about the onset of their mental health problems and/or psychoses, their psychiatric diagnosis or diagnoses, and the impact of psychiatric dis-order on their lives. I learned that talking about their diagnosis was not only tied in with consumers' self-identities. Reference to their psychiatric dis-order also provided them with a meaningful - biomedical - explanation for and validation of the havoc that had been wreaked upon their lives.

Consumers living with schizophrenia or bipolar disorder described its onset as something that happened suddenly, without warning. Morelian thinking of schizophrenia as a phenomenon whereby seemingly healthy adolescents rapidly deteriorate in young adulthood was congruent with consumers' accounts of student days in universities or of holidays in overseas countries unexpectedly interrupted by disturbing symptoms that were subsequently diagnosed as manifestations of schizophrenia or bipolar dis-order; stories of fathers flying overseas and returning their psychotic children into the hands of Australian psychiatry; of psychotic adults travelling home for support and care from their parents. As noted in Chapter 10, not everyone found the support they believed they needed.

Heredity as a causal factor was acknowledged by consumers in terms of their 'predisposition' to psychiatric dis-order, but the most common social causal factor identified by consumers was substance use. *Smoking dope* was viewed as a trigger in their subsequent deterioration and the onset of psychosis. This perception is backed up by 2002-03 data for PSU.[148] Approximately 38.7% (56M, 61F) of 302 patients were referred to a residential or non in-patient drug and alcohol treatment facility. This figure is underrepresentative of the prevalence of comorbidity in psychiatric admissions. For example, in 2002-03, 58 males aged 20-29 years were admitted to PSU. Of these, 28 patients were referred to drug and alcohol facilities. Of the remaining 30 patients who were not

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[148] De-identified client level data for 2002-03 was provided to me by Mental Health ACT.

provided with a referral, six had been admitted with psychotic or mental and behavioural disorders due to multiple drug use, including cannabinoids and hallucinogens.

The process of coming to terms with a diagnosis of a serious psychiatric dis-order such as schizophrenia or bipolar disorder, of working out the right cocktail of legal chemicals to control for symptoms, interspersed with periods of hospitalisation, uncertain accommodation arrangements, and loss of career and relationship prospects, was not only devastating for the consumer; it was also a process that for many was experienced during the course of one's most productive years. Once they had received psychiatric attention, years and several periods of hospitalisation could pass before consumers came to terms with their diagnosis and were accepting of the need for compliance with their medication. Most consumers described the physical side effects of taking medication and, for some, the ongoing struggle of finding a suitable medication. Medication was not always adequate: at least two interview participants received Electro Convulsive Therapy during my time in the field.

Fears of Barbarianism

In an earlier chapter, I noted the observations of Lucas and Barrett, that the Barbarian primitive, existing without culture, dominates our fears of madness (Lucas and Barrett 1995:315). In the course of fieldwork, I discovered that fears of Barbarianism affects not only the researcher and the 'community', it is embedded in and informed by the governmental arrangements for care and treatment, particularly in those institutions vested with powers to detain and restrain the unpredictable and the irrational Other. Within these spaces, an expectation of violence from the psychiatrically dis-ordered is built into the design features for restraining and locking up people, into the authority vested in agents to apprehend and 'escort' to psychiatric facilities those persons believed to be in states of unreason; into the techniques for observing, subduing and returning to reason those persons described as psychiatrically dis-ordered. Fear has been normalised, formalised and codified within these governmental arrangements for managing psychiatric dis-order. Fear is transmitted to all who come into contact with the spaces vested with the powers to detain and restrain unruly bodies. The psychiatrically dis-ordered are doubly affected by fear: firstly, through the impact of the public psychiatric facilities catering for the detention of Barbarians and secondly, in response to the experience of having their freedoms removed.

Alex has been detained in PSU on several occasions. After I sent her a copy of the transcript of our interview, she responded by sending me additional, written comments. Fear, Alex writes, permeates PSU, and is also experienced by those who are involuntarily placed into its treatment and care:

> *There is no real support for a religious person, or rather a spiritual/religious person in that situation. You feel very much on your own and you feel afraid because part of the very valuable thing you do is support marginalised people and even 'different-to-normal' experiences, to an extent.*
> *I am more liberal than the average Doctor or even nurse.*
> *They don't really question you much – even about things that have worried them. They feel afraid to ask questions.*
> *Mental illness brings up so much fear. It really needs resources poured into it. To be given 'love' so to speak until something like fair-ness is achieved.*
> *At the moment it's still surrounded by fear and over-reactions are taking place. Instead of correcting an unusual behaviour back to normal they drug you (literally) and expect you to be ultra-well(?) ultra-conservative. There is still so much fear.*

Alex's observations imply that those who are tasked with her treatment and care also fear her. One explanation for this observation is that PSU caters for those patients who receive a high risk rating and are therefore most likely to require detention and restraint. In this environmental setting of care, fear is an understandable response.

The language of psychiatric primitivism is used by consumers to explain experiences of psychiatric detention. Alex has been admitted to PSU on several occasions for being at risk to her own reputation. In addition to risk to self or others, risk to one's own reputation is a third criterion of admission. She views her stays at the Unit as periods of discipline and self-discipline during which she has to learn to *tame myself down until I become more and more conservative* (emphasis added). Anna described episodes when she has become *promiscuous* or in *moral danger* as a consequence of her manic state, when her libido kicks in, when all her senses are heightened, when she spends too much and becomes overly generous.

In 2002-03, PSU admitted a total number of 302 patients, accounting for 547 admissions. Male patients outnumbered females (157M/145F). Of the 547 admissions, 74.04% (n=405) were involuntary, and 25.95% (n=142) were voluntary admissions. The most common DSM category for admission was paranoid schizophrenia (F20.0), a diagnosis generally associated with dangerousness and attracting the greatest stigma within the community. A total of

43 patients (24M, 19F) were admitted with paranoid schizophrenia. The *locked door* spaces and disciplinary powers of PSU caters for the violent and the disruptive.[149]

One of the more problematic types of patient, in terms of their diagnosis and care, is the personality dis-ordered (patients admitted in 2002-03 = 31). The actions of the personality dis-ordered tend to be associated with transgressions against the moral order. Generally, they do not respond well to a pharmaceutical response. It is not surprising, then, that they are unpopular clients of in-patient psychiatric facilities. When they do get admitted, they tend to be regarded by staff as demanding, difficult, time-consuming patients (in 2002-03, 12 *borderlines* had an admissions rate to PSU of 4.83). It is not uncommon for them to be viewed as bad rather than mad, on the grounds of their non-compliance with the norms of moral propriety. The case of Jake exemplifies this perception of the personality dis-ordered.

I was invited by a family member to attend the court hearing of Jake, who was facing three charges of assault, two of damaging property and one of possessing an offensive weapon with intent. For six years Jake had lived with a diagnosis of bipolar disorder and was treated accordingly. However, his health and well-being progressively deteriorated. This was reflected in behaviour described by his family as ‘volatile’ and ‘erratic’.

Jake stopped taking his medication in response to unpleasant side-effects he was experiencing. This concerned Jake’s family because he had a history of going to a doctor for a few sessions and then refusing to return. Family members believed he was not receiving appropriate care. They submitted an application before the Mental Health Tribunal that Jake be subjected to a psychiatric assessment and treatment order. The Tribunal considered the application and made an order to that effect. Jake’s psychiatrist, however, decided to overturn the Mental Health Tribunal’s verdict because he had come to the conclusion that Jake had a personality disorder. Over the Christmas period, Jake presented at the mental health service in distress. His psychiatrist informed him of his new diagnosis and advised him that, as his condition was not amenable to a pharmaceutical response, he should look in the Yellow Pages for a therapist as the

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[149] In her overview of psychiatric in-patient trends in England in the 1990s, Payne notes that young males outnumber young female admissions, attributing this to: ‘scarce resources are being “rationed” in favour of men … particularly in the younger age groups’ because they are regarded as ‘more of a threat or a risk to the community and are therefore more likely to be removed from the community than women’ (Payne 1999:249).

public mental health service could no longer help him. At the time, the psychiatrist may have viewed his response as a useful technique for getting rid of a troublesome client.

Subsequent correspondence from Jake’s family to various mental health authorities was given to me by a family member. In one letter, a relative noted that in the 12 months leading up to his re-diagnosis, another psychiatrist had tripled the dosage of Jake’s medication and on another occasion, he was given a depot injection. This family member suggested that ‘if [Jake] has been mis-diagnosed with bipolar, then his medication over many years would have been inappropriate and may well have contributed to his erratic behaviour. … Surely if the system has mis-diagnosed [Jake] over many years, the system should now help him recover?’

During the court hearing, the public prosecutor argued that, due to the re-diagnosis of a personality dis-order, Jake was responsible for his actions, that the community had a right to be protected from him, and that a punitive response, that is, imprisonment, was appropriate. The magistrate, however, disagreed with this line of argument. He expressed his displeasure that the ‘protection of the law’, exemplified in the powers vested in the Mental Health Tribunal, had been taken away from Jake without any hearing. The language in the ACT *Mental Health Act* was unclear about the rights and responsibilities of the chief psychiatrist in his/her relation to the client, resulting in an ambiguity regarding whether the psychiatrist had the power to revoke a Mental Health Tribunal order. To the public prosecutor’s dismay, the Magistrate dismissed all the charges.

Jake’s case illustrates how psychiatric dis-order is derived from a complex amalgam of the medical and the moral and secondly, the repercussions of this semantic ambiguity for care and treatment outcomes. Accordingly, persons in mental distress who do not breach cultural norms may have difficulties in gaining access to public psychiatric care and treatment facilities. For example, Nora and Jane who, because they are able to express themselves coherently, are quietly spoken and polite and do not swear or act in an aggressive manner, believe they are unable to gain admission to PSU. Nora has bipolar dis-order. She also has a well paid full-time job and can afford health insurance. Her psychiatrist works at Hyson Green, a private psychiatric hospital. When Nora feels she is on the brink of a psychiatric episode, she is able to *book* herself into *the motel* (Hyson Green) through a process involving her general practitioner and psychiatrist. In the past, when Nora has presented with similar symptoms at PSU, she has been turned away.

Jane is a quietly spoken, polite middle-aged woman. She was diagnosed with depression in 2001. One of her relatives was concerned about her behaviour and telephoned for assistance from the Crisis Team. After spending time talking to Jane in her relative's home, the Crisis Team workers drove her to PSU for further assessment. Upon arrival she was interviewed by a medical officer and told: *you've got depression*. Jane was given a prescription for anti-depressants and shown out the front door by staff. She was on her own and was forced to use public transport to make her way home.

Ward 2N of Calvary Hospital may be a more appropriate facility for the polite and the coherent. In contrast to the clientele managed by PSU, Ward 2N, a mix of public and private beds and no lock-up facilities, tends to cater for *depressives*.[150] Ward 2N, I was told by both mental health services staff and clients, specialises in Electro Convulsive Therapy, a treatment for severe depression. I did not get access to admissions data for Ward 2N and am therefore unable to compare aggregate data for the two psychiatric facilities. The *splitting* up and dispersal of categories of patients is, however, a feature of the governmental arrangements for Community Care, and the differing responsibilities and specialisations of PSU and Ward 2N are reflective of this trend. My differentiation between PSU and Ward 2N is congruent with the ways that PSU and Ward 2N were perceived by interview participants.

There is a perception that each psychiatric facility, through the type of patient it caters for, attracts a different 'class' of person. This was explained by two factors: Ward 2N does not admit involuntary patients while at any given time at least two-thirds of PSU patients are involuntary admissions; and secondly, the association of Ward 2N with the care of depressives.[151] The troublesome clients, non-compliant and in denial of their madness, are thus more likely to find themselves taken to PSU while polite neurotics and depressives tend to gravitate towards Ward 2N.

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[150] This perception of the distinction between the two psychiatric facilities was consistently raised by interview participants.

[151] While Calvary does not have lock-up facilities and therefore does not formally accept 'consumers' under detention orders, it does accept voluntary patients under treatment orders. Even open door facilities have techniques for detaining voluntary patients although these are largely symbolic acts: I learned that staff would adjust the environment a little if a patient was becoming a little restless to leave the ward, for example, by shutting a door.

It is noteworthy at this point to recollect the distinctions made in Chapter 4 between the maniac and the melancholic. In that chapter I described how the maniac has been typecast as ‘alien’ and potentially dangerous and contrasted with the melancholic, suffering an understandable response of a sensitive and middle-class mind to the pressures of living in a modern, western society. These representations of mania and melancholia were reinforced by consumer perceptions of the differences between the type of patients found at PSU and 2N. A consumer who has been psychiatrised at 2N on several occasions unconsciously conflated psychiatric diagnosis with socioeconomic status. It was this consumer’s view that 2N *tends to see a higher percentage of middle-class patients*, and that socio-economic status is a variable that is reflected in the kinds of patients that are sent to each psychiatric facility. Ben believed that the unemployed homeless would find it difficult to fit in with the patients of 2N, a ward he described as catering for ‘middle-class depressives’. An unstated assumption, one that is not dissimilar from nineteenth-century views of degenerates, is that the unemployed homeless are more likely to exhibit the signs of Barbarianism, and are therefore more appropriately placed in the lock up facility of PSU and subjected to the coercive care of detention and seclusion.

* * * *

In this chapter I described the ways in which contraventions against the cultural norms of rationality, responsibility, industry, and progress marked the residents of Kenmore and the consumers of Canberra as cultural Others in need of care. My analysis was guided by the cultural narrative of psychiatric primitivism. In the next chapter, I illustrate how the norms underpinning each of the care regimes give rise to new possibilities for action of the submissive inmate, the educable patient, and the empowered consumer. I propose that the twentieth century arts of care may be epitomised as a history of governmental programs whereby the psychiatrically dis-ordered learned how to be free.

12. Learning to be free

In this chapter I describe the ways in which the granting or removal of freedoms typify and are key to understanding the arts of twentieth-century care. The chapter thus illustrates how freedom has been differentially articulated in each of the three care regimes, giving rise to new psychiatric subjectivities. I describe how liberty as therapeutic technique and privilege governed the Herd Care era; secondly, how the Therapeutic Community regime emphasised patient training for autonomy; and finally, how freedoms in Community Care are managed through the language of risk. The threat of restraint has been available in each care regime as a lesson - a means of teaching the recalcitrant how to be free. I therefore examine some of the continuities as well as the ruptures of the arts of rehabilitative and repressive care. I consider how administrative, legal and psychiatric techniques of freedom and restraint are firstly, relational to the attributed capacities for autonomy of the psychiatrically dis-ordered and secondly, subject to contestation and subversion by both care providers and the recipients of care. At the same time, I also argue that the arts of care are overlapping and that a linear approach for conceptualising rationalities for governing subjects cannot be assumed. Analytical space is thus provided in this chapter to examine informal meanings and practices alongside formal discourses of freedom. I illustrate how at times freedom may refer to a messy and seemingly contradictory conglomeration of practices that may be labelled as rehabilitative and restorative as well as repressive and regulative.

Firstly, I describe how an informal ordering scheme of the Herd Care era existed alongside the asylum's formal classification system; together they determined inmates' unequal experiences of freedom[152] and restraint.[153] I propose that the inmates most likely to experience freedoms were voluntary patients, inebriates and, in general, male residents. In contrast, women were more likely to be deemed in need of greater supervision, surveillance and restraint. Secondly, I illustrate some of the ways in which patient autonomy was 'encouraged' in the

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[152] By freedom in the asylum, I include both formal and informal experiences; including the *freedom from* mechanical restraint and from asylum routines, the *freedom to* move about the asylum's buildings and grounds; and the *unauthorised freedom* of escape.

[153] By restraint, I refer to restriction of movement, including the use of disciplinary mechanical restraints such as the straightjacket, camisole (a variant of the straightjacket), leather muffs, canvas coat, being tied to a seat or the use of the seclusion room. Restriction of movement may also refer to limitations placed on inmates' access to parts of Kenmore's buildings and grounds.

Therapeutic Community era prior to the emptying of the asylum. Therapeutic Community encouraged patient autonomy by introducing new legal categories, individualised care practices, rehabilitation and resocialisation programs, including the wide-scale introduction of the pension into NSW asylums. Some of the ways in which Therapeutic Community was compromised are described, including the prevalence of 'residual' patients and the persistence of Herd Care routines within aspects of nursing practice. Finally, the arts of Community Care are examined, in particular the ways in which authorities' understandings of risk as managerial tool and as therapeutic activity govern mental health consumers through the arts of paternalism and the discourses of consumer empowerment.

Freedom as treatment and privilege in the Herd Care era

> I regret to report that prior to their evacuation, several of the male Inebriate patients and voluntary patients were in the grounds in a state of complete intoxication. This feature exhibited a total lack of discipline so far as these patients were concerned. ...
>
> A practice had crept in of allowing patients to build shacks (from scraps of iron, timber etc.) around the grounds. They are unsightly and are harbours for rubbish and rats.[154]

Two explanations for what the Officer perceived to be the breakdown of order on Kenmore's grounds may be that firstly, both staff and residents were unhappy with the decision to evacuate the asylum as part of the take-over by the Australian Army. The above example may thus be interpreted as a form of resistance to the takeover. Secondly, inebriates and voluntary patients generally experienced more freedoms than other residents. The shacks may have been used to indulge in drinking sessions. The practice of consuming alcohol at Kenmore was not uncommon. Inebriates unwilling to dry out were known to keep stashes of alcohol buried or hidden on Kenmore's grounds.

Contrary to taken-for-granted understandings of homogeneous, custodial and disciplinary order, an array of freedoms formed part of asylum practice. Freedom was both a treatment and a privilege in the Herd Care era. It was prescribed by asylum staff when it was believed to be conducive to their rehabilitation. The granting of freedom represented the asylum's recognition of residents' progress on the pathway to autonomy. It was also a reward for good

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[154] Excerpt of the Evacuation Officer's report to the Inspector-General, dated 29 May 1942, on the evacuation and transportation of Kenmore residents to NSW asylums prior to the Australian Army's take-over of the asylum.

behaviour. Freedom was limited, though, to inmates whose behaviour demonstrated their trustworthiness - a marker of rationality and moral responsibility.

An informal inmate hierarchy operated alongside the formal classification scheme for ordering and segregating inmates in the asylum's spatial and social settings. While it was formal practice to diagnose and evaluate them according to their grade or level of functioning, inmates' attributed capacity for autonomy was also connected to and mediated by their gender, class, and education. The myriad of intersections between formal and informal hierarchies were further complexified by their instability: inmates' rankings could fluctuate as a result of behavioural, diagnostic and legal changes over time, and in response to the personal relationships forged between nursing staff and their charges.

Some residents were deemed more worthy of the privilege of freedom than others. Voluntary patients were the residents formally attributed with the greatest capacity for moral responsibility and rationality, and thus they were more likely to be given privileges. I use the term 'patient' in preference to 'inmate', to denote the higher status, freedoms and capacities accorded to this legal category. Voluntary patients, by virtue of their self-recognition of their madness and corresponding need for treatment, demonstrated a capacity for rationality lacking in the certified inmate.

In recognition of the stigma associated with asylums and madness, administrative concessions were made that disassociated voluntary patients from other residents. Upon admission, their details were recorded in a different coloured pen and they were tabulated separately to the general asylum population. The asylum was also not obliged to divulge information about voluntary patients to government. For example, in response to a letter from the Repatriation Commission in 1950 requesting confirmation of Kenneth Smith's identity and residency, the Medical Superintendent replied: '(i)n the case of voluntary patients, no routine physical description is made on admission'.[155]

During the Herd Care period, (which for the purposes of this calculation I have taken to be the years 1925-58), voluntary inmates at Kenmore and other NSW asylums remained few in number, fluctuating between 0.5 - 2.0% of asylum

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[155] Of course, the necessity or otherwise of routine physical descriptions lay at the discretion of the Medical Superintendent. Tim Hocking, a 16 year old masturbator accused of indecent exposure, was physically examined upon his admission and his case notes included detailed descriptions of the size and development of his genitalia.

resident numbers. Perhaps the most interesting feature of voluntary admissions is their gendered nature. In Kenmore and other New South Wales asylums, male voluntary patients consistently outnumbered female voluntary admissions throughout the Herd Care era.[156] Of the 69 Canberra inmates of Kenmore in the period 1925-51, 19 were admitted as voluntary patients, that is, 16 of 47 men and three of 22 women (Table 12.1 below). The voluntary figures represent approximately 27% of total admissions from Canberra during this period. They are proportionately higher as a percentage of all admissions from Canberra than in the total NSW system, including Kenmore. The dominance of Canberra male voluntary patients may be a reflection of male numerical predominance in the transient lifestyle of a town under construction.

Eight of the 16 men were overseas born. Eleven men were single and one was widowed. In periods of emotional, physical and/or financial crisis, men may have been less able to turn to family and friends for support and assistance. It is plausible that men were more likely to voluntarily turn to an institutional solution during difficult times. It is probably more likely that Kenmore was viewed as an institutional solution by Canberra police, for relocating drunks and vagrants across the border. Twelve out of 16 male voluntary patients arrived at Kenmore under police escort and/or with alcohol problems. The asylum offered them short-term institutional care. They were admitted as voluntary patients, to dry out and to recover from the physical and emotional stresses brought about by their lifestyle and living conditions.

Of the three Canberra women who were voluntary patients at Kenmore during 1925-51, one arrived at the asylum requesting treatment for alcoholism. A second woman arrived at Kenmore two weeks before the asylum's evacuation in 1942. There is no personal history recorded on her file. The third woman, Glenda Hackett, was admitted under an Order. This was subsequently changed to voluntary status. Her case notes reveal she was depressed at the time of her admission because she had been forced to give up her baby for adoption. Hackett was unmarried and the father of her baby had supposedly 'jilted' her.

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[156] In contrast, Brookes' study of Seacliff Asylum discovered that women consistently outnumbered men from 1911, when voluntary admissions were introduced, to 1920 (Brookes 1992).

Table 12.1. Canberra Voluntary Patients, Kenmore 1925-51
Listed in chronological order of admission

Name	**Sex**	**Age**	**Marital Status**	**Length of Stay**	**Comments**
Radkovic	M	38	M	10 mths	Depressed, homesick, overseas born, former soldier, voluntary status changed to Order
Jennings	M	36	M	1 month	Police escort, overseas born
Lyons	M	54	S	3 weeks	Police escort, alcoholism, overseas born
Hughes	M	69	S	3 weeks	Alcoholism, overseas born
Newton	M	47	M	16 admissions over 17 years	Acute melancholia
Hocking	M	16	S	9 months	CMD (Moron), indecent exposure
McNamara	M	53	S	10 days	Police escort, alcoholism
Blakeley	F	56	M	2 weeks	No diagnosis, transfer to Orange
Day	M	34	S	3 weeks	Alcoholism
Hackett	F	30	S	11 weeks,	CMD Epilepsy, Order changed to voluntary status
Faulkner	M	54	M	13 years	MDP (depressive). Died at Kenmore.
Parker	M	21	S	(not available)	Confusional state, alcoholism
Byrne	M	40	S	2 years?	Voluntary status changed to Order, alcoholism, paraphrenia, escapee, overseas born, deported
Frost	F	32	M	10 days	Alcoholism
Smith	M	55	S	20 months, under Order and voluntarily	Former soldier, overseas born, depression, paraphrenia, alcoholism,
Stuart	M	28	S	5 months	Two stays, one as an inebriate
Maloney	M	31	S	4 admissions, one voluntary	CMD epilepsy, charges of paedophilia, police involvement
Porter	M	58	W	3 months	MDP, overseas born
Fischer	M	52	S	5 weeks	Confused state, alcoholism, overseas born

While the voluntary patient occupied a high status position in the asylum's inmate hierarchy, this position was shared with the inebriate. At the same time, inebriates also represented one of the most problematic inmate categories for asylum superintendents. In a report titled 'The immediate and ultimate treatment of the Inebriate', an overview of lunatic asylums throughout the Western world, Dr Manning wrote that inebriates were 'objected to by almost all asylum superintendents' (who believed that) 'ordinary asylums are not fit residences for them' (Manning, cited in Shea 2005:195). In NSW asylums, inebriates were viewed no differently. In his Annual Report for 1937-38, the Inspector-General wrote that inebriates 'are out of place in the wards of a hospital for the treatment of cases of insanity, in which they invariably prove troublesome and difficult to manage' (p. 15).

Inebriates may have been regarded as difficult because alcoholism was more likely to be associated with a 'lack of will' or a 'lack of self-control' than to a lack of rationality (Brown 1995:669-70). While the history of alcoholism has included arguments for a disease model and a psychiatric response, lack of will or self-control are more closely related to morally embedded concepts such as character and personality defects. Furthermore, the inebriate was not as easily infantilised as were the psychiatric and mentally defective residents. Once they had 'dried out', inebriates were generally regarded as sane and intellectually competent persons and, in combination with their 'troublesome and difficult' ways, were not comfortably accommodated within the asylum social structure wherein a paternal Medical Superintendent ruled over his child-like subjects.

The inebriate tended to be described as a cunning strategist by asylum superintendents of Northern European and American asylums, a person who 'was likely to abuse the asylum by using it as a place to dry out between debauches' (Brown 1995:672). The view of the inebriate as clever and cunning resonates with Kenmore's experiences of inebriates. For example, Ian Stuart, a former inebriate inmate of Kenmore, voluntarily admitted himself to the asylum in 1950. During his stay, Stuart, while given gardening privileges at Goulburn Hospital, took a taxi into town where he subsequently bought alcohol and shared it with other inmates. The account of his transgressions resonates with the observations made by the Evacuation Officer at the start of this chapter.

A consequence of privilege: escape

The act of escape is an illicit freedom, for escape is a form of liberty that is exercised by the inmate on his own terms, contrasting with liberty as a privilege or treatment granted to inmates at the discretion of staff. Escape also symbolises a transgression against the ideal asylum subjectivity of the submissive inmate. Not surprisingly then, in the case of his recapture (and it was almost invariably a male escape), he was marked as an escapee – not to be trusted – and punished by isolation in the seclusion room.

The number of escapes during 1925-41 ranged from five to ten per year or 0.68%, based on the figure of 7.5 out of an average population of 1100. In the 1950s, escapes began to increase in frequency, averaging between 40-50 escapes per year or 4.09%, based on the figure of 45 out of an average asylum population of 1100. By 1958-59, male escapes escalated and represented on average five escapes from Kenmore per month. In contrast, women's escape figures remained relatively stable throughout the 25 year period. By 1963, and in a separate register to the Medical Journal which had been abolished in 1959, escapes were referred to as 'unauthorised absences', and during a nine month period there were almost 200 escapes by male inmates, half of whom were inebriates, in comparison with nine females, four of whom were inebriates. By this stage, letters of formal notification of escape to the Director of NSW Psychiatric Services had been replaced by a standard form. The steep rise in escapes in the early sixties may be attributed to the end of the locked door era of Herd Care and the growing influence of the open door policies of Therapeutic Community, when the arts of freedom were extended to a greater number of asylum residents.

It was not surprising to discover that of all Kenmore's inmates, the inebriate - 'cunning and intelligent'[157] - represented the category of resident that was most likely to attempt escape: *we used to get sick of bringing them back*. In 1940, for example, the escape rate for the main population was 0.59% and for inebriates 8.69%. By 1958-59, escapes had increased, with a rate of 5.06% for the main population, and 33.84% for inebriates. It is plausible that the prevalence of inebriates in escape figures may have been related to their level of mental functioning and that consequently, they would not have been subjected to many if any medical treatments. Also, and unlike escapes by psychiatric inmates, inebriates were more likely to plan their escape from the asylum with at least one other inebriate, not infrequently for the purpose of getting into town and going on a drinking spree.

In addition to inebriate status, escape trends were shaped by gender. I tabulated asylum escapes in roughly five year intervals over a 34 year period: a total of 11 women (including seven inebriates) escaped from Kenmore during

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[157] Kenmore Hospital Medical Journal entry that recorded a multiple escape as 'four male Inebriates together – cunning and intelligent – in the night'.

1925-59 in comparison with 161 men (including 69 inebriates). To a certain extent, this disparity may be accounted for by reference to the higher number of male inebriates in the asylum. To a greater degree, perhaps, the gender disparity in escape statistics may be explained by consideration of the asylum's division of labour.

The division of inmate labour at Kenmore reflected societal norms governing gender appropriate occupations. For reasons relating to their attributed sexual vulnerability and accordingly, their impaired capacity for autonomy and greater need for 'protection', females tended to be kept under greater surveillance than men. In general, men worked outdoors and women indoors. Able and trustworthy men could expect to work on Kenmore's farm, in artisan workshops and in other manual positions. There were also a small number of indoor clerical positions available to them. In contrast, able women cleaned or worked indoors in the laundry or in the sewing room. This division of labour was typical in other asylums of this era.

The spaces from which inmates were most likely or least likely to effect their escapes paralleled the gendered division of labour. Working outdoors gave men a greater freedom of movement and, after they had gained the trust of their supervisors, a relaxation in surveillance standards. Exposure to and knowledge of Kenmore's grounds gave men more opportunities for escape. Brookes notes a similar trend at Seacliff Asylum: '(e)scape from the routine of asylum life was far more possible for men than women since able men were put on outside work and hence could escape surveillance and disappear' (Brookes 1992:141).

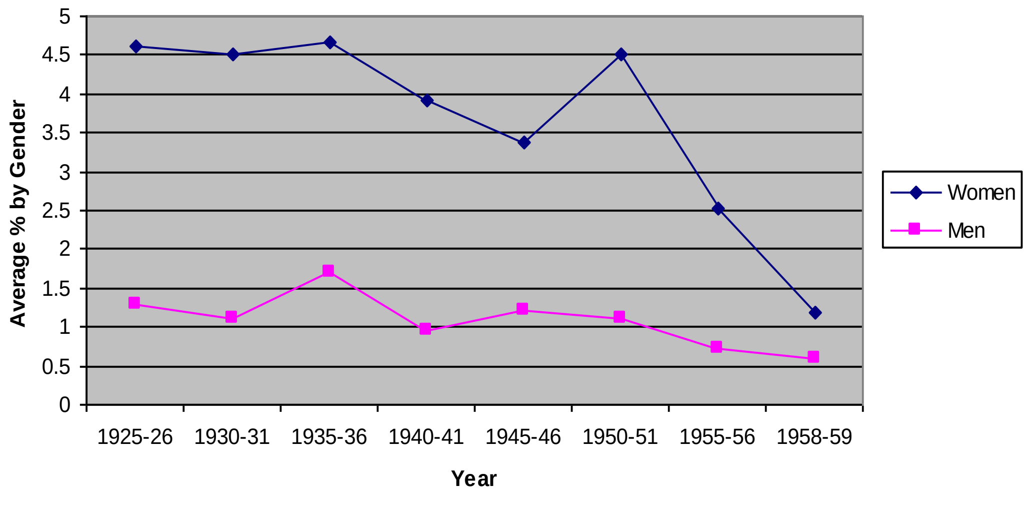
Commentaries throughout the Medical Journals on male escapes are familiar entries. In general, freedom combined with outdoor work correlated with a higher risk of escape: 'they are generally trained to do a certain routine job of work and after a time are progressively given more responsibility and less observation'; 'he had the freedom of the grounds ... we had over a period of time been making every attempt to arrange for his reintegration into the community'; 'granted the privilege of the grounds'; 'in work gang'; 'mechanic – working'; 'escaped from wood yard'; 'escaped from garden'. Escapes from the wards usually took place within the early hours of the morning. Some escapees managed to secrete tools into the ward and, over a period of time, remove stops from windows. Collaboration between inmates was more likely to result in a successful escape but, as noted earlier, teamwork was most likely to occur amongst the inebriate population, for example, in 1950 when two inebriates escaped over the ha-ha wall.

Four male and two female Canberra inmates attempted escape. Their stories are outlined in Appendix 2. No doubt, apart from the occasional outing, women had less exposure than men to Kenmore's geography beyond the wards and subsequently, less knowledge of the lay of the land. The gendered division of labour that confined women indoors was thus a contributory factor in the low number of female escapes.

A hierarchy of punishment

Seclusion rooms and a diverse array of mechanical restraints were available for the management and control of difficult patients.[158] While men dominated the escape figures, it was Kenmore's women who dominated the asylum's restraint and seclusion statistics. A woman inmate was 2-4 times more likely to be restrained than a man inmate. Figure 12.1 below illustrates these gender disparities in a graph that shows the average percentage rates for restraints and seclusions among the female and male populations over a 34 year period.[159]

Figure 12.1. Average % of Mechanical Restraints and Seclusions by Gender, Kenmore Hospital 1925-1959



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[158] For example, former nurses described the use of mechanical restraints as a form of care for those inmates who, if given the freedom of movement, would paint themselves with their own faeces.

[159] It may be useful to reflect on the practice of using the seclusion room as a standard punishment for recaptured escapees. A botched escape attempt thus resulted in the appearance of the escapee's name in the seclusion statistics. Some of the seclusion figures for men may thus represent failed escapes.

The average percentage rates of restraints and seclusions began to decrease during the 1950s, most likely in response to the wide-spread introduction of chemical restraints such as chlorpromazine in 1953 and increasing concerns regarding the appropriateness of custodial care, coalescing in the *Mental Health Act* in 1958. Table 12.2 below illustrates average restraint numbers and percentages alongside total female and male population figures:

Table 12. 2. Average episodes of mechanical restraint and seclusion numbers and percentages by gender and total population figures, Kenmore Hospital 1925-1959

	Women	**Men**	**Total Population**
1925-26	**23.51** (**4.61%**/509)	**7.82** (**1.29%**/602)	**31.33** (**2.81%**/1111)
1930-31	**23.24** (**4.50%**/516)	**6.88** (**1.12%**/614)	**30.12** (**2.66%**/1130)
1935-36	**22.32** (**4.67%**/477)	**11.04** (**1.71%**/644)	**33.36** (**2.97%**/1121)
1940-41	**20.31** (**3.93%**/516)	**6.22** (**0.95%**/651)	**26.53** (**2.27%**/1167)
1945-46	**4.64** (**3.38%**/137)	**2.28**(**1.2%**/190)	**6.92** (**2.11%**/327)
1950-51	**24.94** (**4.52%**/551)	**5.57** (**1.10%**/502)	**30.51** (**2.82%**/1079)
1955-56	**14.06** (**2.52%**/557)	**3.76** (**0.71%**/528)	**17.82** (**1.64%**/1085)
1958-59	**6.13** (**1.18%**/518)	**3.5** (**0.60%**/574)	**9.63** (**0.88%**/1092)

As Figure 12.1 and Table 12.2 indicate, the average number of restraints and seclusions per week as recorded in the Medical Journals was relatively low, particular when one takes into consideration that the asylum population averaged over 1000 during this period. In conversations with former nurses, I was advised that the use of mechanical restraints was largely confined to inmates of the refractory wards. Based on my examination of case notes, I would suggest that these figures represent an incomplete tabulation of the use of restraints and seclusions in Kenmore. I made periodical checks and comparisons of Canberra case notes with Medical Journal entries and my review revealed that not all instances of restraint and seclusion were recorded into the Medical Journals. It is plausible that the heavy workloads of nursing staff during this period and, possibly, lack of time or aversion to administrative work, resulted in their privileging the record keeping of individual case notes over the maintenance of aggregate records as set out in the Medical Journal. The incidence of the use of restraints and seclusions in Kenmore, as set out in Figure 12.1 and Table 12.2, is thus under-reported and represents a partial and incomplete account of care.

Furthermore, Figure 12.1 and Table 12.2 do not provide any information about the length of each episode of seclusion or restraint. The Medical Journals suggest that periods of time spent in the seclusion room or in a straightjacket or camisole could vary from an hour to years. As noted above, a woman was more likely to be deemed in need of restraint than a man. The rationales for restraint were similarly ordered by gender. While men were mainly restrained for aggressive, violent, self-mutilative, and destructive behaviours, women's restraint was more likely to be justified as a kind of punishment for inappropriate behaviour, including bad language, 'mischievous conduct', 'faulty habits', 'interfering', 'spitefulness', 'impulsiveness', and 'depraved' behaviour. Dangerous behaviour featured more frequently for women than it did for men.

The names of several women routinely appeared into the Journals. A small group of women gained notoriety at Kenmore for their bad behaviour during mealtimes. These women were routinely placed in seclusion every day throughout their stay on the grounds that they disrupted other inmates during the serving of the main meal. Their period of seclusion generally lasted no longer than the duration of the meal. Other women were placed under mechanical restraint throughout the day for periods lasting many weeks. One woman was tied to a seat for years, and her story is set out in Appendix 3.

Nursing staff offered several explanations for differences between the male and female restraint figures. In an era without access to effective psychotropic medication, inmates were more likely, as nurses would say, to *act out* or *go off*. One male nurse with work experience in the Herd Care era suggested that women were more aggressive than men and that the restraint figures are an accurate reflection of the different levels of aggression between the genders. In contrast, a female nurse who had also worked in this care era connected it to men's greater freedoms. Women in the 1940s and 1950s, she mentioned, were viewed as inferior to men and the female role did not give them as much freedom of expression. In general, female nurses offered the explanation that their male colleagues were not as conscientious about making notes as their female counterparts and that male restraint figures were underreported. It was also suggested that men would be more likely to use informal, unrecorded disciplinary measures, including the threat or promise of a physical response to bad behaviour. In addition, Brenda, who commenced working at Kenmore in the 1940s, commented that:

> *men were stronger and more able to fend off an attack so if the women saw that someone was starting to get a bit on the edge they might have put them in restraint because we could be knocked around a lot easier ... when you dealt with some of those patients, they had the strength of an ox when they went off and it would take five or six of us to restrain them.*

The majority of gender studies on asylum histories focuses on women and are unable to provide comparative analyses of male and female care experiences. Brookes' study of Seacliff Asylum does examine gendered experiences of restraint (during the period 1890-1920), noting that women required restraint more frequently than men, but provides no figures on the gendered use of restraint (Brookes 1992:145). Figures are, however, provided in Showalter's writings. Colney Hatch was an asylum in England where, in the 1800s, women were likely to be secluded and restrained for up to five times more than males for 'deviations from ladylike behaviour' including 'being violent, mischievous, dirty, and using bad language' (Showalter 1985:81). Showalter writes that women had less opportunity for physical activity than men and that this may have contributed to their 'bad behaviour' (Showalter 1985:80-81).

Another plausible explanation for why a greater number of women were restrained than men is based on the hypothesis that 'bad' men are more likely to be sent to gaol and 'bad' women to the asylum (Dwyer 1994:107; Grob 1994:90; Mitchinson 1987). One could postulate that the women of Kenmore were more likely to be violent women whose behaviour had become unmanageable at home. Because aggression is not an acceptable norm of middle-class femininity, it may also have been presumed that violent women were mad and secondly, that the asylum represented the most appropriate holding institution for this class of women.

Grob's analysis of gendered differences in the nineteenth century inmate population of Willard Asylum reveals that violent men were more likely to be sent to gaol and violent women sent to asylums. Grob notes that 56.3% of Willard's inmates were female: '(c)hronically mentally ill females were more likely to be sent to a state hospital, while males ... were more likely to be confined in penal or welfare institutions' (Grob 1994:90). Reinforcing a hypothesis that 'bad' men are more likely to be gaoled than admitted to asylum care, Mitchinson's study of the committal systems of medical certification and warrant reveals that warrant committals of persons described as dangerous automatically included a period of imprisonment while hearings to consider pleas of insanity were processed. A large proportion of men were admitted to the Toronto asylum via the gaol and, due to overcrowded asylum conditions, some of these men continued to reside in prison. In contrast, women were more likely admitted to Toronto Asylum via family's use of the committal system of medical certification. Drawing on this analytical framework, 'dangerous' women found themselves sent to Kenmore, whereas 'bad' men had the additional institutional solution of imprisonment at Goulburn Gaol.

One could accept the view that Kenmore's women, as they are represented in the Medical Journal, were more troublesome and dangerous than men. However, as noted in Chapter 3, medical records are not neutral artefacts of truth, but also reflect the norms and values of the times and of the author. Secondly, female inmates were placed in restraint by female staff, and male inmates were restrained by male staff. Therefore, behaviour that female and male nurses were each responsible for regulating included actions and attitudes which they deemed as inappropriate for their gender. Related to this point, one could propose that the gender norms governing masculinity allowed men greater freedom of resisting their confinement than the norms of femininity permitted women. Women who resisted their asylum detention and who asserted themselves against staff and other patients were transgressing the norms of appropriate feminine behaviour and therefore more likely to be punished than men.

Training for autonomy in the Therapeutic Community era

In contrast to Herd Care techniques that were productive of a dependent inmate body, Therapeutic Community was productive of new conditions of personhood. This care regime promoted normalisation programs with the aims and objectives of developing or restoring residents' skills and capacities and facilitating their reintegration within the community. The arts of Therapeutic Community emphasised patient freedom and responsibility:

> patients, generally, are being accorded a higher degree of freedom and individual responsibility. (SPS 1961:7)

While a submissive resident was still the norm, this was a resident imbued with and shaped by the attributes of the educable patient. In 1963 the Medical Superintendent of Kenmore Hospital reported:

> the introduction of a new treatment program following along therapeutic community lines. ... A full program of group therapy and group activities has been constituted and well over one hundred patients are involved. The effect of this program has been felt throughout the whole hospital and it has been pleasing to note the increase in activity of patients in most wards. (SPS 1963)

Mundane activities were recast into opportunities for fostering patient normalisation that, in combination with the Activities of Daily Living Skills test, evaluated patients' readiness for living in the community.

> *A lot of them, what they done when they started, ah, letting patients going outside, before they were let outside, they'd, all these houses along this side of the road, they used to put four patients up in there to see how they could look after themselves. They cooked their meals, make their bed ... if they passed that test, then they were put out into the community.* (Roger)

Asylum residents were encouraged to maintain or increase their social skills: 'in many cases, wards are virtually empty during the day while the patients are engaged in occupation and social therapy' (SPS 1963:15). Activities were structured by an orderly routine, thereby inculcating within them the habits of regularity, punctuality and responsibility. Games and other recreative activities, sports, group discussions, and shopping expeditions encouraged patient skills development that were ideally productive of a subject capable of living autonomously in the community.

Nurses referred to the array of staff required to run the programs of rehabilitation and resocialisation:

> *a school teacher teaching people how to read and write, physiotherapists, occupational therapists, everything. ... We ran programs, ... to teach people, to try and teach them how to get into the community ... We tried to teach them basic cooking ...* (Linda)

In 1968, it was announced that in NSW asylums, '(t)he recreation of patients has assumed a far greater importance than formerly' (SPS 1968:17). By the 1970s, Therapeutic Community care practices were entrenched within the asylum:

> *Nearly every patient went out to something every day or had somebody coming in and doing some sort of um training program with them. You know, there was something for most people. Only the really, um, the most handicapped or mentally handicapped and so on didn't get something special a day.* (Linda)
>
> *During the 1970s ... we had a lot of facilities in the hospital ... (there was) a school teacher teaching people how to read and write, physiotherapists, occupational therapists, everything. It was good. Those were the years when the amenities had money ... sporting events participating and observing, walks around [the] ground, also picnics at Kenmore Dam, industrial and occupational therapy ... provided a selection of activities for each patient, e.g. carpentry (new and restoration work), art drawing, painting, ... knitting, sewing, snack prep, crocheting, general discussion groups, indoor and outdoor bowls. ... There were routine interward visits to integrate male and females for card games, dancing, supper. In 1968 there was a building 'set up' as a school room and we would take patients to learn how to write their name and read as many had no or very little schooling. Money handling skills was [sic.] practically non existent or none at all. ... all patients were given the opportunity to learn essential skills in readiness for living as independently as possible in the community.* (Caroline)

In Chapter 6, I described how the 1958 NSW *Mental Health Act* impacted on Kenmore's built environment during the Therapeutic Community era by introducing new admissions patterns and classificatory practices. In Chapter 9, I described how these changes, in particular, declining patient numbers in a more permissive institutional environment, impacted on nursing practice, including the introduction of more individualised arts of care such as staggered showering and bathing routines. Symbolic of these shifts were the renovation of bathrooms and toilets in most wards to provide patients with privacy and the personalisation of sleeping arrangements. It was believed that giving inmates more privacy and personalising their living environment had a positive impact on their behaviour:

> *You got a lot more respect from a lot of them because they had a room or a little bit of privacy ... we eventually got everybody a wardrobe ... we got them their personal things where possible. We'd try and get photos or whatever and we'd scrounge and scrimp to get money to ... buy little bits and pieces for them to go next to their dressing tables.* (Linda)

Arguably the most influential technique of Therapeutic Community was the introduction of the pension, a move productive of new conditions for personhood, one that reinforced the ideal of individualised care and created a ripple effect across daily routines in the asylum.

The introduction of the pension

To prepare them for their reintegration into community, long-stay patients were retrained in the values and skills of consumerism. With the increasing emphasis on patient discharge and integration into community, training programs were particularly important for those who had been admitted to Kenmore prior to the introduction of decimal currency in 1966:

> *The money system had changed since they'd been in hospital. They might have been in hospital for 30-40 years. They had no idea how to handle money, only their small gratuity they got which they used in the canteen for lollies ... They didn't know how to budget money and they had to try and learn the difference between dollars and cents ...* (Linda)

The connection between rehabilitation and money handling skills was formalised in response to legislative changes made to the *Social Services Act* regulating eligibility rights to pensions and benefits. This *Act* had stated that:

> (w)here an age or invalid pensioner becomes an inmate of a hospital for the insane, his pension shall, without further or other authority than this section, be deemed to be suspended. (Section 48, *Social Services Act* 1947-64, cited in Bundey 1965:12)

The removal of Commonwealth pensions upon certification within an asylum was standard practice until 1968, for ‘it was held that the mentally ill were *ipso facto* incapable of managing their affairs and therefore unfit to be entrusted with pensions’ (Bundey 1965:12).

While the Commonwealth was responsible for administering the Social Services Act, under jurisdictional arrangements States had autonomy over the distribution and spending of Commonwealth health funding. States were ultimately responsible for deciding how much money they were prepared to invest in the care, control and treatment of the psychiatrically dis-ordered (Bundey 1965:12). In the meantime, pensioners who entered into asylum care lost their social service benefits[160] and the Commonwealth did not directly contribute to their maintenance above the generic health budget allocated to the individual states. The rationale for this legislation included the belief that asylum stays were usually lengthy and that reintegration into community ‘was the exception rather than the rule’ (Bundey 1965:12). It was therefore regarded as a waste of Commonwealth money to continue paying pensions to asylum inmates. Furthermore, asylum residents were perceived to be lacking in the capacity to manage their own money.

During the 1960s, the *Social Security Act* was increasingly regarded as an archaic legal instrument, particularly with the rising numbers of voluntary patients in asylums ‘who after all are not legally insane’ and the greater availability of psychiatric treatment in public hospitals ‘admission to any of which does not effect eligibility for social service benefits’ (Bundey 1965:16). The ineligibility of patients for pensions was antithetical to the principles and practice of training, resocialisation and reintegration:

> (t)he realisation that his pension has been suspended and he consequently has no money, not even the price of a newspaper, must adversely influence a patient’s self-concept, and could scarcely be regarded as part of a therapeutic process. Likewise, the fact that the mentally ill are “different” in that while in mental hospitals they lose their eligibility for pensions (and their right to vote) must surely help perpetuate an unfavourable attitude to mental illness on the part of some members of the public. (Bundey 1965:16)

In addition, it was believed that people would delay entering into treatment if this resulted in a loss of pension, and that this delay would adversely affect their prognosis for recovery (Bundey 1965:17). The legislative framework governing

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[160] The exception was returned servicemen and inebriates whose pensions were allowed to be held in trust (Bundey 1965:14).

eligibility rights for pensions and benefits was amended in 1967 and the first NSW pension payments were made in early 1968:

> An application to the Commonwealth Department of Social Services for payment of pensions to patients involved in the re-training and re-education programme was successful and payments commenced during the last week in February, 1968, for 70 patients. (SPS 1968:17)

While the introduction of pensions may be described as a gain for patient rights, an entitlement to one-third of their pension (the remaining two-thirds going to the asylum for their accommodation and care) represents only a small amount of money. A more significant benefit was that for the first time states received additional funding for asylums, in the form of pensions, on the condition that they demonstrate that rehabilitation programs had been introduced into daily routines. Pensions were thus linked to the asylum's capacity to provide rehabilitation programs for patients:

> The effect of this is that the State will benefit by the deduction for maintenance of a moiety of each patient's pension, but more importantly the patients themselves will benefit considerably because of their financial independence – a potent instrument towards their rehabilitation. (SPS 1968:6)

The formal linking of consumerism with rehabilitation and resocialisation was not unique to mental health governance. For example, Rowse describes the reasons for and impact of the transition from rations to cash for Indigenous Australians. By virtue of their cultural Otherness, however, it was believed that not all Indigenous Australians had the capacity to handle money. In 1959, the assimilation policy framework that set out pensions and benefits for Indigenous Australians had been extended 'to all except "nomadic and primitive" people' (Rowse 1998:14). Pensions and benefits were available only to those who lived close to the civilising influences of white settlement. While Indigenous residents of settlements, missions and pastoral properties were in receipt of Commonwealth benefits, like the residents of asylums they also 'received at most a "pocket money" portion of their benefits … the rest still went to the institutions which rationed them' (Rowse 1998:14).

Alongside the expansion of rehabilitation programs, another beneficial repercussion associated with the introduction of pension payments was the interest that accrued in a central account, and the profits made by patient spending in the asylum canteen:

> *Their money went directly into the office and I think it sort of went into one big account ... the interest from that one big account became, uh, a patient amenities type thing that provided – it wasn't law that patients had to get the interest off their own money because they weren't all individual accounts. It was like a big hospital account.* (Linda)
>
> *When pensions 'came in', each patient could draw money to spend from their trust account each week, and spend it on anything they liked. There was a canteen on campus and patients enjoyed this activity.* (Caroline)

Canteen profits were transferred into an amenities fund for patients and staff. As patient numbers declined, the canteen went out of business and the downturn in the asylum economy impacted on the quality of life for patients.

In NSW asylums, the first patients to receive pensions were the mentally defective or 'intellectually handicapped', as they were referred to in the 1960s:

> Following consultations with the Commonwealth Department of Social Services, the Commonwealth now grants pensions to intellectually handicapped patients over the age of 16 years provided they are being trained towards rehabilitation and are accommodated in ward units separate from non-pensionable patients. (SPS 1968:5)

The Medical Superintendent of Peat and Milson Island reported on the award of pensions to 70 intellectually handicapped patients who were now supposedly involved in retraining and re-education programs. He noted an 'improvement in the clothing of their choice and there has been a marked improvement in the self-confidence and bearing of the patients as they acquire their own prized possessions and feel that they have a place in the community' (SPS 1968:5). In the same Annual Report, Kenmore announced that two wards were 'qualified for invalid pensions'. In 1969, pensions were extended to the psychiatrically dis-ordered:

> The payment of social services benefits was extended during the year by the grant of benefit to a further group of psychiatric patients. The criteria of eligibility for this benefit are that the patients are undergoing treatment or training to fit them for return to the community, they should have reasonable access to the community, the prospective period of treatment should be relatively short term or have reached the stage in treatment where discharge is possible but has been delayed because suitable placement in the community is not available. The State is being put to some expense in meeting requirements of standards of staffing and accommodation in respect of the patients receiving social services benefits and two-thirds of the benefit is retained as a charge for maintenance, the patient receiving one-third. The availability of this regular source of income for personal spending has had a very beneficial effect on the patients and is greatly assisting the efforts of the medical and other staff in their efforts to resocialise and rehabilitate the patients towards ultimate discharge from hospitals. (SPS 1969:7)

By 1970, Kenmore reported that out of a population of 880, 100 were inebriates[161] and 700 were in receipt of pensions:

> All the wards, with the exception of two kept exclusively for inebriates, have been gazetted as areas eligible for pension payments. The payment of pensions has now been in operation for approximately a year, and there has been a marked improvement in the patients' appearance and dress, and in their capacity to handle their own money.
>
> There is no doubt that this pension payment has enabled staff to rehabilitate some patients who in past days would never have left the hospital. With the fall in the patient population endeavours are being made to provide accommodation for each patient, so that they can maintain their own clothing and take pride in their own appearance. As a result of these rehabilitation programmes, Kenmore now has virtually no closed wards. (SPS 1970:39)

One could suggest, then, that the introduction of cash for asylum residents contributed to accelerating the availability of rehabilitation and resocialisation programs of Therapeutic Community.

A Herd Care approach was not feasible in the context of patients' individual pension accounts. The new expectation that nurses would manage individual patients' access to their pensions put a strain on daily ward routines:

> *Linda: When I came back in 1972 the patients had got the pension. ... And in that time it was, well ... a really big learning process. I mean, you've got to take into account we weren't trained to handle money and here we were then responsible for their pensions ... they ran it from the office of course. ...*
> *Doris: So if a patient wanted to buy something, how would they go about it?*
> *Linda: Well, the patients could draw spending money once a week.*
> *Doris: So they'd go to the office to do that?*
> *Linda: Well, yes, we had to fill out a form and this had to be signed, and signed again by the supervisor in charge of your area, and it went to the office, and you'd take the patients up once a week up to the office and they'd give them their money ... There was a limit on what they could draw ... Those who smoked, it was difficult to get clothing for them. Those who couldn't handle their cigarettes, you allotted them a cigarette, after a meal, etc. There were a lot of things to learn because at first we did it all in bulk, everything was sort of bulked together, and then we learnt we had to have a separate area on the shelf for each patient to keep their toiletries and their cigarettes ... we had pigeon-holes made because the auditors got onto it ... and they made it very strict for us that we couldn't bulk purchase, we couldn't bulk supply. Everything had to be individual. And they, they came around and wanted to know what we were doing with the patients' money and if we had – like a lot of the patients would go up and draw money each fortnight and ... you'd have other people in the ward who'd pinch it. Steal! ... So we'd find it for them, and you'd have a money tin, and they'd come to you and say, can I have so much. Well, of course at first we started off, that was all bulk. But then we had to bring it in that we had to have a list of how much each patient had and how much they had left, and ... when they'd taken it out. And you'd have to sign it and have it*

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[161] Perhaps because they may have been tempted to spend their money on alcohol, inebriates were not eligible to receive one-third of their pensions during their confinement. Their pensions were not suspended but rather accumulated in a bank account. In the meantime, they could earn cigarettes and money informally, by doing errands for nursing staff.

> *witnessed, and all this sort of thing because I suppose, well I presume in Sydney hospitals and that, they'd had a lot of problems with losing money and ...*
> *Doris: It sounds very fiddly.*
> *Linda: It was, it was a real learning thing, considering we'd had no training with money, and then we suddenly became very responsible, and people were losing jobs because of the mishandling of the monies and things like that. As you can imagine, this always happens in any job where there's* [indecipherable] *money it can happen. There were cases where people were losing their jobs and getting in quite a bit of strife, or you know, being reprimanded ... at the mishandling of money, um, but I always felt sort of sorry for them because it was something that was really thrust on us, virtually overnight. And you had to just learn ... how to do it, and how to do it properly. ...*

Patient labour in NSW asylums formally ceased at around the same time pensions were introduced, on the grounds that it was exploitative because the rate of remuneration was below award rates. Another reason put forward was that the skilled patient, as a subsidised worker, had a competitive edge over local artisan groups. Not all nurses were in favour of the abolition of patient labour:

> *Brenda: All the patients used to have a job ... 'work gangs'. Then it came in that the patients were being exploited and they weren't allowed to do this ... it broke some of their hearts, ... some of them died, ... and they did nothing, ... they weren't allowed out so they just sat in the courtyards and died. ...* [with reference to those patients who worked in the laundry] *They were useful, that was their group therapy – they were occupied all day. See when they stopped all this patient labour, as they called it, they sat around doing nothing, you know ... people deteriorated ...*
> *Linda: It gets back to the nursing staff too, to have to try and occupy them and, you know, work out programs and activities and everything for them, and you didn't have enough staff to do it.*

Contesting the Therapeutic Community

The introduction of Therapeutic Community did not take place overnight but proceeded at a slow and uneven pace over two decades. Elsewhere in this thesis I have suggested that for much of the 1960s Herd Care practices co-existed alongside the liberal care represented by Therapeutic Community. Unlike the advances in patient rehabilitation so optimistically portrayed in the State Director of Psychiatric Services' Annual Reports, the reality of introducing pensions in the asylum was a slow, messy transition towards individualised care and the recognition of individual needs. Nurses found ways to subvert the system or at least reconcile the new expectations within existing ward routines, and some elements of Herd Care practice were retained to make nurses' working lives more manageable. There were limits to individualised care available in the asylum:

> *When I first took over in charge of a ward I remember I went there and the previous charge had bought a lot of bulk clothing and I had the job of trying to fit it on people and you know label it for them. And then they probably hadn't bought things like well, a lot of the wards to start with weren't buying individual pyjamas and things like that. They'd still – cause we were used to having three sizes on the*

> *shelf – and you have this pair, and you have that pair and, and at night, in those days, to stop escapes and everything, we used to collect their clothes and wrap them up into a bundle – but that's another story – um, but we gradually – it took years – to actually get everybody clothed because with the pension you had to wait for their money to bank up too. And different people had different needs. Like some were more destructive of their clothes, some grew out of them, you found some things that were more suited for people, and I mean, you know, it was entirely taste as far as charge nurses were concerned and commonsense tells you you've got a ward full of 60 people, you can't, you'd be forever taking each one into town individually when you could get a lot at the canteen. And what you'd do was go over and pick out a heap of staff and bring it back to your ward and fit it about for people, because you had an idea of what they liked or what would be suitable, but, umm, it did take years to eventually get everybody from their own underclothes right through to their pyjamas and things.* (Linda)

In addition to nursing staff, some patients were not ready for the liberal care approach of Therapeutic Community, and were initially bewildered by the introduction of new freedoms:

> *You know it took a while for them ... especially when they brought in this open door business, they just stood at the door and they got stuck because out there was a no-man's land for them because they hadn't been out for ... could be twenty, thirty years. Once they opened the door, they just more or less stood there. A few of them we had to go and bring them back because they kept walking.* [laughter] *... Yeah, it took a while, and once they put, you know, one foot out, and there was nothing much happened, so then they put the other foot out, and thought "this is alright!"* [laughter] *... We had to look for a few of them. A few of them, you know, they were just roaming around the grounds.* (Roger)

A disciplinary mode of care involving high levels of surveillance remained requisite for the chronically unwell and the acutely ill. In the Therapeutic Community of the asylum, Herd Care techniques were available for those residents deemed incapable of exercising freedoms in a morally responsible and rational manner. In Chapter 6, for example, I described the ongoing upkeep and availability of the *wet end* in the Therapeutic Community. And despite the efforts of staff, a residual group of patients remained that was unresponsive to the programs of patient improvement. In 1967, the Director of State Psychiatric Services noted that:

> (a)s the problems of institutionalisation are overcome it is those patients who are more easily rehabilitated that are discharged first, leaving a residual group who become progressively more difficult to get out of hospital. (SPS 1967:3)

In line with the policy ideal of community integration, asylum staff designed a targeted intervention for the more resistant patient:

> The two project wards, Male 3 and Female 3, which have an integrated programme continue to be one of the dynamic areas of hospital rehabilitation for the chronic long stay patients. (SPS 1967:49, with reference to Kenmore Hospital)

The self-governing consumer: 'I am responsible for myself'

In a move foreshadowing the emergence of a new care regime, community volunteers became increasingly involved in Kenmore patients' care, providing 'patient entertainment' in the form of 'card parties and trips', and generally assisting 'in the day to day activities of the patients' (SPS 1964-66:31). In 1968, Kenmore reported that:

> (a)ll female wards and some male wards have voluntary workers attached to them. The situation is most successful in the female wards and in the integrated wards. (SPS 1968:16)

No doubt asylum authorities also recognised the financial benefits of an unpaid workforce who:

> perform a most useful service in the ward situation and in group activities with patients in association with recreation officers and occupational therapists. (SPS 1967:9)

Over time, community organisations were invited into the asylum 'with a freedom which would have been undreamt of ten years ago' (SPS 1970:40). As Kenmore welcomed a growing number of community representatives through its gates, the surrounding region was increasingly habituated to the presence of asylum patients and staff and to the availability of mental health services in the community.

Today, the empty asylums attest to the successes of Therapeutic Community in liberating both the psychiatric profession and its patients from their institutional confinement. Neoliberal political values of entrepreneurialism and consumer responsibilisation are reinforced in policy discourses of Community Care that assert the rights and responsibilities of self-managing mental health consumers and rationalise the withdrawal of the welfarist state (Australian Health Ministers 1991; Ericson 2005:663; Henderson 2005:242-244,250; Shamir 2008:7-8). Thus, Nora described the importance of learning to accept her diagnosis and her responsibility for maintaining compliance with her prescribed psychotropic medications, as preconditions for freedom from hospitalisation. Sophia referred to her self-care strategies, in particular self-isolation. She has learned: *I have to look after myself*. When Sophia feels that she is going downhill she goes to her bedroom and stays there until she can face the world again. Jeremy described how he has made a *rule* to be *self-disciplined and self-controlled* in his habits, including being responsible for taking his medication in a regular and timely manner. Emily has learned not to expect on clinical support when she believes her condition is beginning to spiral out of control for ultimately, *I am responsible* *for myself.* Emily's reflection is based on her experiences with scarcely resourced public psychiatric inpatient facilities.

The neoliberal discourse of entrepreneurialism and responsibilisation has been accompanied by downturns in public spending and cuts to hospital beds resulting in a 'denial of access to needed mental health care' (Carney 2007:482).[162] Therefore, being taken to PSU by the police, the crisis team or by a carer does not automatically guarantee one's admission to the psychiatric facility for the criteria of admission have been narrowed in response to declining resources (Sawyer 2005:284). Based on his extensive experiences in the mental health sector, an NGO worker confirmed that it is not unusual for a person who has attempted suicide to be discharged after only one night at PSU.

Those consumers who meet the admissions criteria and are given a bed may feel the pressure to *get well quickly* for the luxury of time to recover from psychosis and to restore well-being is not available in the public psychiatric facility. Fast-acting and powerful psychotropic medications are the main treatment and inmates whose conditions have been stabilised by medical means are discharged as quickly as possible to make way for others.[163] Furthermore, continuity of care was not guaranteed and an appointment with a mental health care professional might not be available until a week following discharge. Not surprisingly, the responsibilisation of consumers is a desirable attribute not only for their own psychological welfare but to ensure they do not become a burden on the human and budgetary resources of this care regime.

Not everyone is comfortable with neoliberal attributions of greater autonomy to consumer agency. Critiques of twentieth-century mental health government have moved from concerns of excessive and illegal custodial care to the risks of not providing adequate supervision for the psychiatrically dis-ordered (Hazelton 2005:231; Richmond and Savy 2005:223):

> If the middle classes were concerned about "their own" going into psychiatric institutions, they were equally, if not more concerned about 'the other' coming out of them (Engstrom 2003:203).

Government has responded to community fears of living with the uncertainties of neoliberalism by harnessing the actuarial technique of risk assessment to the

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[162] Bed figures for this care regime are provided in Chapter 7.

[163] This admissions trend is in contrast to consumers' (n=6) experiences of Kenmore, described as *an indefinite stay place.* Kenmore didn't *push you* to get well quickly. In contrast to the revolving doors of Canberra's psychiatric wards, Kenmore offered consumers the 'choice' of time to recover before returning to 'community'.

management of the psychiatrically dis-ordered. Risk is a way of referring to the uncertainties of a care modality that promotes the responsibilisation and freedoms of the psychiatrically dis-ordered (Pratt 1999:143; Snowden, cited in Rose 2002:210). The term has become the dominant means of rendering the ‘realities’ of Community Care ‘in order to govern’ an unpredictable population group (Ericson 2005:660; Hazelton 2005:233; Richmond and Savy 2005:219; Rose 2002; Sawyer 2005). Two meanings of risk emerged in the course of my fieldwork. These meanings were situated in specific geographic and organisational locales and associated with different service provider roles and responsibilities.

Managing risk in the acute-care psychiatric facility

Sawyer draws on her experiences of working as a clinician in a Melbourne-based Crisis Assessment and Treatment (CAT) Team in her description of a shift in clinical care, from ‘crisis consciousness’ to ‘risk consciousness’ (Sawyer 2005). Members of the CAT Team are regarded as specialists in risk due to their position ‘at the “emergency” or “crisis” end of community-based service delivery’ (Sawyer 2005:288). Sawyer observes that a therapeutic consciousness ‘which may involve counselling, support, psycho-education’ has been outsourced from the CAT team to ‘other service providers, including private psychiatrists and counsellors’ (Sawyer 2005:287). She argues that risk assessment has structured and narrowed ‘the parameters of service provision’, representing a shift from a therapeutic, open-ended approach to an administrative paradigm ‘reliant on checklists’ (Sawyer 2005:286, 293).

Sawyer’s argument is congruent with my analysis of field data relating to the arts of care that dominate the acute care facility of PSU. The parameters for public mental health service provision in the ACT have narrowed, resulting in Sawyer’s ‘divide’ between risk consciousness and therapeutic consciousness. The formal narrowing of the concept of ‘care’ has led to the increased emphasis on risk management. This development is ironic in a care era which emphasises the minimisation of involuntary hospitalisation and the maximisation of freedoms in the community; consumers may now experience traumatising and custodial care reminiscent of the most disciplinary arts of the Herd Care regime.

By the time consumers have reached a level of risk that requires their hospitalisation they are in an acutely unwell condition that renders them visible to staff through a psychiatric spectrum of symptoms of pathology. They are regarded as having lost the capacity to make informed decisions about their care. Why else would they compromise their reputation or their financial position? By the time 'consumers' arrive or are 'escorted' into the locked door environment of this acute-care facility and are assessed at high risk to self or others, the dominant psychiatric response is one that emphasises their custodial and disciplinary care.

Cubicle 7

In addition to consumers' descriptions of the traumatising experience of being forcibly taken like criminals to PSU by police officers in paddy wagons, a humiliating experience narrated by one consumer involved admission via the Canberra Hospital's Accident and Emergency Department. During admission, Jay was placed in Cubicle 7, a room located in A&E. Staff place psychiatric patients in Cubicle 7 to facilitate observation of the patient: the top half of the door to the cubicle is visible to staff. At the same time, Cubicle 7 inhabitants are also visible to people who have nothing to do with their treatment or care. Placement in Cubicle 7 *labels you immediately as a loony*, robbing one's dignity and privacy. After complaints were made about the half-door, the height of the door was raised. In the meantime, however, one of its walls has been replaced with glass.

The prospective inmate is viewed as irrational, irresponsible, untrustworthy and immoral:

> *Helen: ... if someone comes in and they've got a razor blade hidden, we have to look for it. Because the patients themselves have to be safe, they are suicidal and they're threatening self-harm and have a razor blade hidden you have to look for it. And they can be hidden in quite personal places. You wouldn't believe where some people hide razor blades. Um, but we still have to look. .... because they can hand the razor blade to someone else who is suicidal – 'I want to cut myself.' 'Oh here, have a razor blade'. Or, it can be done to another patient or a staff member. See, it's* [PSU] *got to be safe for everyone. And so, the same rules have to apply for everyone. And that is a contentious issue. Consumers don't like it when they are admitted to hospital. It's very degrading.*
> *Doris: What, because,*
> *Helen: They are there against their will. And then they have a body search. That's degrading. Then they give them medication which knocks them out for a few hours. And that's degrading. It's degrading to get henchmen come and* [pause] *see, the wardsmen do a remarkable job and they don't get any, any thanks at all. They come, we press a button, and come running from the main part of the hospital. ...*
> *Doris: But then, how do you avoid those situations? You can't really, can you?*
> *Helen: You can't, because the patient's out of control. They don't want this to happen, but the thing is, it's treatment and has to happen. ... Sometimes, like if a person is manic, they don't necessarily see their energy level or the degree of disruption they cause. And so they, and for them to receive treatment they would need medication first, you know, they need medication ... They can do things that compromise their reputation or compromise their financial position, ... And their own health.*

Working in a setting with acutely unwell inmates raises occupational health and safety issues for both staff and other residents. This demands inmates' conformity with rigidly imposed institutional rules and regulations. It also provides the staff with powers to mobilise overt forms of coercion such as involuntary detention and treatment including 'time out' in the seclusion room, if faced with any resistance. If threats do not achieve the desired behaviour, *henchme*n are deployed to restrain *out of control* inmates and thereby enable staff to mobilise 'treatments'. Staff interactions with their charges are reminiscent of a paternalistic response out of step with the discourses of Community Care. Reference by Victorian service users to the 'parental' role of in-patient psychiatric facility nurses is reminiscent of the role of Kenmore nursing staff, as set out in Chapter 9:

> someone I work with (with a psych nursing background) brought up the notion of protection, and that (the psychiatric nursing role) is like being a parent, and that got me thinking. Because there's that on the one side, and on the other is the feedback I've so often heard in ward consumer-only groups, 'We are treated like children', and that's said very disparagingly, and in a hurt way. I can see that it's meant to be nurturing, the parent as nurturer, so it's like there's these things feeding into the role that aren't articulated. (Roper 2003:9)

These dynamics between care providers and recipients raise a tension,

> between the construct 'health consumer' implying that service users are in control, and the controlling position retained by the service providers. (Hazelton 1995[b]:105)

Eileen was admitted as a voluntary patient, supposedly for 24 hours but ended up staying for a week. She wanted to go home but was told by staff - *if you try to go, we'll place an order on you* – this, despite the fact that Eileen believed she was acting *compliant* and *polite*. Her experiences with PSU have made her cynical of the term *24 hours' observation*: she now believes that it is *just a way of getting you in*. Eileen's views were reinforced by other consumers: *they can do what they like with you and the paperwork gets done later* was a familiar refrain among the more experienced psychiatric survivors. This 'threat of reclassification' is also discussed in the literature (Hazelton 2005:232).

A paternalistic culture in combination with a reliance on medical treatments and the pervasiveness of 'risk consciousness' impacts upon the kinds of interpersonal relationships nurses are able to develop with clients:

> ... it seems to be a repeated complaint that nurses do their set work and stay in the Station and do the work and have very little interaction with the patients and there have been times when as a patient I’ve really needed something, and a nurse is nowhere to be found, literally for hours … (Roper 2003:9)[164]

Unlike Kenmore, where nurses were routinely rotated through the various wards representing the different categories and capacities of patients, PSU nurses are constantly exposed to the severe symptoms of psychopathology of involuntary residents. Not surprisingly, this has given rise to a culture of custodialism and confinement, reinforcing a Herd Care response of ‘efficient “keeping”’ rather than ‘interaction’, for the main factor in staff patterns of interaction with their charges is the perception of inmates’ incompetence (O’Brien and Golding 2003:170, 173; Hazelton and Clinton 2002:96). There is evidence in Australia and in the United Kingdom that as the ‘threshold for admission’ has been raised so too has the culture of custodialism (Richmond and Savy 2005:219; Hazelton 2005:233).

Eileen’s first experience of hospitalisation was 30 years ago, in Ward 12B of the former Woden Valley Hospital. In those days, she claimed, the ward was not just for acute cases. It was staffed by people who had time to *talk to you*. Ward 12B did not have the powers to involuntarily detain patients and the criteria for admission were broader. She believes that the existing PSU, with its narrow admissions criteria and custodial powers, is creative of a climate where staff respond very differently to the patients because a different set of caring practices are required. During her stay at PSU, Eileen received no counselling. She was given food and pills. No staff were available to sit down and talk to her. Eileen phoned up her Case Manager, outside PSU, for counselling.

The dynamics of care

> It seems that the same act depending on where it is performed can have two quite distinct interpretations. (Farrell and Dares 1996:171)

Farrell and Dares describe some of the similarities between seclusion rooms used in psychiatric facilities and the cells of solitary confinement in penal institutions. Whereas in the former setting seclusion tends to be referred to as a psychiatric treatment, in the latter it is generally used as a punishment. The authors add that while the use of seclusion in the psychiatric facility may be described as ‘therapeutic’ by staff, studies documented in an international nursing journal reveal that the target of seclusion, the patient, is more likely to associate it with

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[164] Overseas studies have found similar results (Richmond and Savy 2005:219).

the penal institutional role of punishment (Farrell and Dares 1996). An Australian mental health consumer and activist Simon Champ has similarly described his experiences in the 'time out' room as periods of punishment reinforcing his 'sense of being an outsider' and 'feelings of guilt and the shame I felt at having a mental illness' (Champ 1998:56).

I highlight these twin purposes of the seclusion room to illustrate an intrinsic difficulty in untangling the repressive from the rehabilitative 'techniques of intervention to modify "socially undesirable behaviour"' (Scull 1979:266), where discipline may be used as an instrument of normalisation as well as punishment and normalisation may rely on techniques of surveillance and patient conformity as well as foster autonomous behaviour. For example, not all consumers or former inmates and patients agreed with Champ's view of seclusion. While there was a perception amongst consumers that seclusion does more harm than good, there was also acknowledgement that the time out room provided a solution for dealing with patients who are aggressive and disruptive to other patients as well as to staff. An Official Visitor commented on cases where people have been kept in seclusion – solidly – for several days, even a couple of weeks.[165] The second example refers to one patient who was *out of control*, being extremely aggressive to the extent of causing injuries to nurses.

Belinda experienced seclusion for several weeks during a period of hospitalisation in Kenmore. When she was admitted to the asylum she was in a manic state and any form of stimulation would set her off. She now believes that the treatment had a therapeutic effect by completely desensitising her. Charles has also experienced time out in the seclusion room. He recalled one occasion where nurses were giving a patient an injection against her will. He started yelling out, questioning their authority. Charles was subsequently injected and became unconscious. He spent the night in a seclusion room. In the morning, he recalled, everything was back to normal. Says Charles: *if I'd have been a nurse, I would have done the same thing*.

At the same time as consumers acknowledged that paternalism remained integral to mental health care, they also acknowledged its rationale. As one consumer noted, even if one had extensive mental health literacy and experience

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[165] While the seclusion room continues to remain an historically enduring reminder of custodial care, it represents only one of many forms of power available to agents of government. A relatively new symbolic artefact of the powers available to clinicians in the Community Care era is the 'black box', a briefcase community nurses take with them on home visits (O'Brien 1999:158).

and skills as a consumer advocate one might still need just as much closely supervised care as the next patient, because *when a person is unwell* [they are] *not the best judge* of what is good for them. Eileen referred to a friend and fellow advocate who, after sharing afternoon tea with PSU staff announced *I'm going to lie down*. He subsequently committed suicide in his room.

Although Anna maintains that she was not treated as someone who had any reason or intelligence during her stays in PSU, she also acknowledges her reliance on the *system* for care. When the symptoms of bipolar dis-order take over she feels *abandoned* by family and friends. And while he was distraught with the loss of his freedoms, Charles subsequently believes he violated his rights to freedom when he became delusional, for an insane person is already in a *prison of your own mind*. Ever mindful that his rights to freedom may again be taken away, Charles has learned to submit to fortnightly injections.[166]

The 'dignity of risk' in the community

In contrast to a discourse centred on the management and control of risk is an understanding of the term 'risk' that asserts that 'risk taking is at the heart of community care' (Harrison, cited in Stickley and Felton 2006:28). Indeed, risk taking may be therapeutic and enhance 'growth and recovery', whereas the 'protectionist' approach endemic of inpatient psychiatric facilities limits individuals' opportunities and freedoms to make choices (Stickley and Felton 2006:29-30). While Canberra NGO workers acknowledged the *vulnerability* of their clients, this attribute was generally viewed as an unavoidable *risk* of living in the community.[167] Jennifer mentioned that she spent the first six months as an outreach support worker worrying about the possible *risky situations* her clients might place themselves in on weekends. People, she learned, ultimately make a range of choices - to suicide, to seek services, to go interstate on the spur of a moment. She believes that, apart from *wrapping people up in cotton wool*, there is no way to stop people from choosing to participate in a self-harming activity. In the freedoms of the community *they get to do what they like*.

Jennifer has found it easier to do her job since coming to the realisation that people enjoy making their own decisions to *live their own life*. Recourse to a

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[166] Similarly, Anna described how surveillance of her psychiatric condition continues beyond discharge through monthly blood tests that assess her compliance with medication.

[167] In contrast, parents of adult children living with a psychiatric dis-order tended towards a protectionist and disciplinary care modality, as discussed in Chapter 10.

paternalistic response is not an option for NGO workers because it does not form part of the ideological repertoire of their practice.[168] Workers also suggested that community organisations are less likely to be constrained by rules and are thus more likely to respond to clients' needs in flexible and creative ways. However, at the same time as they valued therapeutic risk taking workers also recognised that the behaviour of some clients may reach an unacceptable level of risk to self or others, and it was at this point that they turned to *clinical managers* or the *crisis team* for 'support'.

The empowered consumer

In the mental health sector the term 'access' implies an ability or right to access the services, programs and activities of Community Care. Access and empowerment are keywords of mental health policy discourse (*National Mental Health Policy* 1992, *National Standards for Mental Health Services* 1996, *National Mental Health Plan* 2003-2008). In 2001, the World Health Organisation stated that 'community care is about the empowerment of people with mental and behavioural disorder' (cited in Hazelton 2005:237). To empower or to self-empower implies an enabling and liberating process that may result in a subject having greater control over his or her life.

One could presume that self-empowerment and access to services are mutually reinforcing terms, for example, by accessing services one may also be engaged in a process that is self-empowering. For Pratt describes this era of government as a shift in the 'relationships between subject and state' whereby 'the dependent subject of welfarism, protected from risks, and on whose behalf the state would intervene, is replaced by the juridical subject of neo-liberalism, now granted rationality and responsibility – free to decide for him / her self, as it were' (Pratt 1997:135). In the course of fieldwork, however, I discovered that it is possible for patients to access services in ways that disempower them, and patients may empower themselves by not accessing services. For while consumers are encouraged to exercise their choice in the mental 'health care market place' (Hazelton and Clinton 2002:88) most of the rehabilitative programs are optional, providing consumers with the choice whether or not to participate in their rehabilitation. Whereas the patients of Therapeutic Community were

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[168] At the same time, one should not disregard that NGOs' facilitative agenda includes 'education, 'persuasion', 'support' and 'encouragement' – subtle forms of coercion.

actively ‘encouraged’ and ‘supported’ to participate in rehabilitative and enabling activities, mental health consumers may choose not to engage in these programs. They may choose to self-isolate and self-confine in asylums created by and arising out of their own agency. Conversely, their participation may be constrained by their capacity to exercise choice, by their mobility, by their social location, and by program funding and resources.

During the past 25 years, Belinda has for the most part been unwell, spiralling between mania and depression while at the same time living with the disabling side-effects of physical and pharmaceutical treatments. Consequently, Belinda has not been in a position to make a lot of friends or to develop long-standing relationships. Instead, she has been much more dependent on her parents than other people of her age generally are. Belinda leads *a tiny little life*, one that is kept necessarily *tiny* because she *can’t deal with any extra pressures*. Similarly, eight consumers participating in a New Zealand study ‘described lives with sparse activities and social relationships’: ‘Brett’s days were empty. … He used smoking to help mark the passage of time’ (Hocking, Phare and Wilson 2005:301).

The disabling - and personally devastating - effects of a psychiatric dis-order may constrain the capacities of the mental health consumer to independently negotiate the landscapes of therapeutic and social support available in the community. James lives in a public housing unit. His behaviour has contributed to his being rejected by both the community and most family members. His movements are self-confined, limited to a small geographical area. He has no social life and no friends. His is an isolated and introspective existence. While James does have a measure of independence, living alone in a public housing unit, he still requires a lot of support: he does not know how to access services and his ongoing independence is reliant on the efforts of his parents. The governmental anathema of the publicly dependent client lives on, albeit in the more acceptable – informal and private - form of the dependent child.

In response to my question on where and how she accesses care, Nicole described her strategies of watching TV and tuning in to her own *internal resources*. When she is not participating in community self-help programs for managing her psychiatric dis-order and coming to terms with childhood sexual abuse, Jane leads a quiet lifestyle: *I isolate myself*. Because of her experiences with sexual abuse she is distrustful of people. Doing housework takes up most of

Jeremy’s day. Once a week, though, he and two other clients are collected by a community worker and taken grocery shopping. On occasion they might go on other outings and excursions. From time to time, a volunteer from the Connections Program will drive him to church; on other occasions he will catch a taxi, subsidised by government.

Sam has agreed to take high levels of medication to avoid hospitalisation. At the time of our interview, Sam told me that he had not been in hospital for 14 months. He attributes this to the new medication he has been prescribed. He is supposedly on a *heroic* dose – up to 10 times higher than the normal dose. The side-effects of taking his medication mean that Sam sleeps up to 16 hours a day, has gained weight, and is unable to work or have relationships with women. He gets annoyed when people ask if he is *functioning well*. What does the term really mean, he asks me? Does it mean getting work? Or does it mean *I just want to spend my time in bed*? In that sense, Sam believes he is *functioning well*. Should one interpret this to mean that he is empowered? For at first glance, it appears that Community Care has provided Sam with little more than the freedom of ‘simply “not in a hospital”’ (Leighton 2000, cited in Richmond and Savy 2005:219).

In addition to individual capacity, the limits to accessing the restorative and integrative programs of Community Care are usually related to structural issues, that is, the availability or lack of resources. In conversation with a consumer who was also the interim president of the management board for a mental health community organisation, it emerged that s/he did not have an email address and consequently was disadvantaged because the main medium of communication between board members was electronic mail. I sent an email to two workers of a peak body overseeing the establishment of this organisation, outlining the consumer’s situation and suggesting that they consider providing some training and/or resources to facilitate consumer access to electronic mail technology – my email was unacknowledged. It appears that the policy term ‘access’ tends to remain an ideal, while the keyword of empowerment includes the freedom to live in ‘asylums’ of isolation, boredom and despair.

The limits of Community Care

Although asylums have been depopulated and dismantled, their functions have been dispersed rather than dissolved in the care regime of Community Care.[169] Chester notes in her review of the history of deinstitutionalisation in Victoria that community services 'are, in the main, the fragmented parts of the psychiatric hospital that have spun off into smaller, but still institutionalised settings' (Chester 2005:280). The experiences of many seriously and chronically unwell people have included transinstitutionalisation. The new asylums are symbolic of the limits of Community Care.

The Lodge, located on the grounds of Ainslie Village, may be described as a micro-institutional space within a social and physical landscape resembling an asylum. The Lodge provides long-term accommodation for 15 adult men diagnosed with a psychiatric dis-order who may also have drug or alcohol issues. Daily Lodge routines centre on the regular provision of food and medicine. Workers assist residents to access the community, including church groups, art classes, and exercise programs. Some residents are *supported* to join men's groups, anger management and detoxification programs. There is generally a slow turnover of residents and the worker I interviewed was aware that the Lodge is regarded by most residents as *home and their community*. Indeed, in an earlier chapter I described the physical setting of Ainslie Village where,

> (a)part from the obligations of compulsory activity tests or health care appointments there is little need to leave the Village. There is a view expressed by many residents that they wish to be left alone to live their lives in peace. To some extent this is an expression of not wanting to engage with the world outside Ainslie Village. ... Location of most essential requirements within the Village reinforces this insular lifestyle... (Tania Parkes Consulting 2002:21)

A reluctance on the part of many Village residents to engage with the *outside* community is an attitude that goes hand in hand with their institutional dependency, an anathema in a care regime that emphasises consumer autonomy. However, not everyone has the capacity to live in the community without supports or without coming to the attention of government agents. Nor should one assume that Lodge residents regard paternalistic care as a phenomenon that hinders their

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[169] Reminiscent of Activities of Daily Living assessments at Kenmore, consumers described trips into the community, including bus rides with other PSU patients – *fruit loops* – and staff, which one person described as a means for evaluating consumers' social competencies. Consumers were aware that some residents did not pass this test; indeed there have been 'incidents', including escapes as well as fights. Anna, acutely aware that her behaviour is being monitored by staff, describes the excursions as a humiliating experience. In contrast, another consumer reported how much she enjoyed getting out of the ward.

journey towards self-actualisation and empowerment. Furthermore, as long as the community continues to reject and ostracise the signs of cultural otherness, institutional care may provide the only ‘asylum’ or ‘sanctuary’ for these psychiatric survivors.

Although institutional dependency may be seen as defeating the aspirations of the architects of Community Care, it would undermine psychiatric survivors’ well-being and recovery to experience unstable and uncertain living arrangements, including being shifted from one accommodation place to another. Citing research undertaken in Melbourne by Holmes, Hodge, Bradley, Bluhm, Hodges, Didio and Markulev (2005), Richmond and Savy note the trend of ‘homelessness “in passing” as these patients move through a variety of housing options around Australia’ (Richmond and Savy 2005:220). From the 1980s onwards, Phillip boarded with friends from time to time and lived in group houses run by Canberra mental health services, with mixed experiences. He also had a week at Ainslie Village, which he describes as a *scary place*. On two occasions he lived at Watson Hostel, a supported accommodation facility. Most of the residents were middle-aged or elderly. Both Jeremy and Phillip felt that staff were disinterested in their work and that residents were routinely over-medicated into *zombies,* to keep them compliant for staff. Phillip now lives in a public housing unit, which he describes as *a luxury in comparison with sharing* [accommodation with] *dysfunctional people.* Phillip goes out of his way to avoid interaction with other consumers, which he believes is not good for his mental health.[170]

During an interview, an Official Visitor of Canberra’s psychiatric facilities referred to three occasions over a recent 12 month period where patients had been asked to leave PSU but had no suitable accommodation to return to. The Official Visitor gave an example of one person who had recently gone off drugs and was reluctant to go back to a refuge where the majority of residents were still using. This person admitted to the Official Visitor that she would find living in such an

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[170] Phillip’s opposition to socialising with consumers may be connected to a range of factors, including but not limited to his socioeconomic position prior to the onset of symptoms, and his experience of and response to the impact of psychiatric dis-order. When he commenced showing signs of psychosis he was studying at an overseas university. Subsequent family rejection contributed to a sense of shame that, coupled with years of disabling symptoms, resulted in a loss of status and cast him to what he described the *bottom of the heap,* a social location which, in Phillip’s view, is lower than that of a drug addict. However, not all consumers shun other psychiatric survivors. Anna believes that working in a consumer organisation has raised her political consciousness as well as her self-esteem. It is important for Anna to be with like-minded people, to have flexibility in her working hours in an environment where people had understanding and acceptance of mental illness.

environment too tempting and refused to leave PSU. The Official Visitor intervened, and the person was allowed to stay in the psychiatric facility until more suitable accommodation arrangements were made. In addition to this case, the Official Visitor referred to two other clients, one who ended up living in a tent (at the tail end of autumn), followed by a stint living in a car; the other who was ejected from a flat owned by the crisis team after two days (after being promised five). This person was given the flat because at the time she was threatening to commit suicide. After the Official Visitor's intervention, a place for the woman was found in a group house.

The above cases highlight the important and ongoing issue of access to accommodation and other services (Hazelton 2005:237). The Official Visitor's clients (above) were women. In Canberra, access to supported accommodation favours English-speaking white males. A Richmond Fellowship worker stated that female clients never constitute enough numbers to make a group house and consequently, women are unintentionally excluded from NGOs operating on limited financial budgets where, of necessity, *majority rules*. In addition, persons of non-English speaking background are similarly underrepresented in group houses managed by NGOs. Community workers are well aware that certain population groups may be excluded from accessing services, and a respite care worker of Warren I'Anson House described how, in response to an identified need in a non-English speaking community, he brought together a group of women for a weekend of relaxation, activities and support.

It is not surprising that recovery and well-being will be compromised if consumers do not have access to stable and safe accommodation. This is exacerbated when consumers are managing other stressful life situations. Phillip described a period of hospitalisation in PSU in the 1990s. In addition to an ongoing lack of family support, he had lost his job and a relationship had just broken up. Despite staff awareness of his social circumstances, there was no follow-up after his discharge to see how he was coping in the community.

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This chapter explored how the subjects of care have learned to be free through the arts of encouragement and support, education and training, discipline and punishment. I described the arts of freedom and examined how they have been co-opted into a therapeutic paradigm espousing concepts of liberty. While shifts in twentieth-century, liberal political rationalities of government, from disciplinary to facilitative care regimes may be observed, I also observed how there was more than one regime in effect at any time. I ascribed the co-existence of different care regimes to the unstable and fluctuating capacities attributed to the psychiatrically dis-ordered that call into play the powers of detention and the powers of freedom. At the same time, I noted that the arts of freedom are also relational, contextual, and variably interpreted by care providers and recipients. For the subjects of care, then, meanings of freedom may at times contradict the set of governmental practices prescribed by the arts of Herd Care, Therapeutic Community and Community Care.

13. Conclusion

This thesis has traced some of the differences and overlaps between and discrepancies within the twentieth-century regimes of Herd Care, Therapeutic Community and Community Care. I proposed that care is driven by a moral ethos and noted similarities between this Australian 'care system' and the principles of moral treatment. They each utilise techniques for developing morally and socially appropriate behaviour in a process that involves the redefinition of mundane activities into sacred arts of therapy (Bloor *et al* 1988). They each articulate visions for a moral environment by drawing on idealised representations of family and community. The asylum was designed in accordance with principles of a 'moral' architecture, while mental health community landscapes are described by their planners as therapeutic, humane and enlightened. They each acknowledge the importance of relationship. The care provider is both a role model of civility and an instrument in the surveillance of the care recipient. Accordingly, each care regime has been situated in a thematic arrangement in keeping with these premises. Understandings of each of the three care regimes were developed by focusing on their environmental settings and the relationships and subjectivities they are productive of.

It is logical to presume that accounts of twentieth-century mental health government may trace a linear history punctuated by institutional ruptures in the provision of care. In the Community Care era, for example, care for the psychiatrically dis-ordered is no longer confined to a landscape separated from the community. This care regime thus marks a physical rupture from the asylum, for care is now provided in the settings in which the recipient resides. Whereas once the asylum embodied the policy of *lumping* together cultural Others in a holding institution, the community symbolises a trend of decentralising or *splitting* the provision of care in accordance with the diverse *needs* of subjects.

In addition to expectations of linearity, historical accounts of twentieth-century mental health government may also be guided by policy narratives of progress, when subjects of care learned how to be free. Whereas classification schemes of the asylum once ordered inmates' movements through wards based on their assessed capacity for autonomy, self-governing consumers are now encouraged to take responsibility for navigating the diverse terrains of community in response to their fluctuating and differing *needs*. The function of 'community' is thus premised on a conceptualisation of the psychiatrically dis-ordered as self-managing and self-responsible agents.

In contrast to these taken-for-granted assumptions, my thesis has attempted to problematise the notions of linearity and progress. It has contended that continuities are discernable in the core that is intrinsic to this century's care regimes. While they may be articulated differently in each of the care regimes, the arts of segregation and integration, regulation and restoration form part of an ongoing governmental concern of conferring social identity 'on the very beings whose social non-existence is being sanctioned and materialised' in order to manage them better (Gauchet and Swain 1999:269). While I asserted that the 'real' subject of care is a slippery and elusive construct, I also observed that the arts of care are productive of possibilities for action of the psychiatrically dis-ordered. It is in this sense that the arts of care 'make up' people and that the subjects of care may be 'known'. I described the punishments for bad behaviour, the protections for the vulnerable; the managerial techniques for containing the violent; and the programs for training subjects to be autonomous and free. I described how these techniques were available in each care regime.

I argued that the act of care is not only a technique of therapy but that it also encompasses interpersonal dynamics that are looped into beliefs about psychopathology. An example is the care provider using the psychiatric condition of a recipient to mobilise punitive measures that are little more than moral evaluations of behaviour that departs from dominant cultural norms. I explored some of these dynamics between care providers and their recipients. The subject of care at times emerges as an untrustworthy and irresponsible child in need of a protective and disciplinary response. Families described their unwell relatives as *weird,* i*rresponsible, uncooperative, recalcitrant*, vulnerable and *dependent.* The language of nurses suggests they viewed themselves in a parental relationship to their charges, and this nursing role was formally acknowledged by authorities. Nurses described their favourite patients as *pets* that they were mindful not to *spoil*. Subjects of care were also described by their care providers as violent and assaultive, unpredictable and self-destructive, in need of restraint.

Furthermore, I considered how the psychiatrically-disordered are recognised as subjects of care by eliciting the cultural narrative of psychiatric primitivism. Transgressions against culture may not only induce fears and anxieties in *us* but they provide justification for segregating, restraining and detaining the irrational, irresponsible and unpredictable Other. The premises of psychiatric primitivism may also explain some of the discernable continuities in the arts of care.

Thus, while the bricks and mortar of the asylum no longer have a place in the settings of Community Care, the arts of institutional care continue to inform consumers' experiences of mental health governance. The freedoms that tend to be associated with Community Care were not, as the previous chapter illustrated, bound to this care regime, just as the arts of discipline were not confined to the asylum. At times, consumers' capacities for autonomy are compromised by risky behaviours, in which case a disciplinary and punitive care modality reminiscent of the custodialism associated with the asylum is available and ready for mobilisation. The metaphor of family that was used to describe the family formation of the asylum and the relations between nurses and their charges has not been abandoned in these neoliberal settings of Community Care. Even in these permissive landscapes of choice and freedom, authoritarian and paternalistic techniques are inscribed within the environment and disciplinary powers are available for those in need of a punitive response. Alongside the objectives of recovery, then, are the managerial tactics for containing unpredictable and irrational Others, and these twin roles are embedded in the design features of each care regime: while the asylum has been described as an institution oscillating between a prison and a hospital, *locked door* spaces have also been built into the facilitative settings of community.

There is no doubt that the arts of twentieth-century care may be typified in terms of the greater freedoms available for the psychiatrically dis-ordered through a shift in their government, from a disciplinary to a facilitative approach. However, it would be simplistic to assume that these distinctions exemplify ruptures between the arts of repression and rehabilitation for while discipline implies the overt use of power, freedom relies on the capacity of subjects to be self-disciplining. Secondly, and related to this point, we have seen that not all subjects are attributed with the capacity for autonomy. The arts of care will thus continue to be available, to protect and to discipline, to train and to empower those persons deemed in need of care.

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APPENDIX 1.

BATHS.[171]

REGULATIONS FOR THE GUIDANCE OF ATTENDANTS

1. Every Patient is to be bathed immediately after admission, and on the usual bathing days afterwards, unless exempted by Medical Order. Should there be the slightest doubt as to the advisability of bathing any patient, owing to sickness, feebleness or excitement, immediate reference should be made to the Medical Superintendent, or one of the Medical Officers.
2. The name of every patient not having the customary Bath is to be inserted in the Daily Report.
3. In preparing the Bat the COLD water is always to be turned on first.
4. Before the patient enters the Bath the temperature is to be ascertained by the thermometer, and is not to be less than 8 8degrees nor above 98 degrees. In case of the thermometer being inefficient from injury, etc., all bathing operations are to be suspended until another is obtained.
5. Not more than one Patient is to be bathed in the same water. Any infringement of this Rule is to be entered in the Daily Report.
6. UNDER NO CIRCUMSTANCES WHATEVER are two Patients to occupy the Bath at the same time.
7. During the employment of the Bath, the room is never to be left without an Attendant. At all other times the door is to remain locked, the room to be kept clean, and the floor dry.
8. On NO ACCOUNT is the Patient's head to be put under water.
9. In the Bath, the body of each patient is to be well cleansed with soap. After coming out of the Bath especial care must be taken to dry those patients who are feeble and helpless and to clothe them as rapidly as possible.
10. The keys of the Hot Water Taps are to be kept at all times locked up and inaccessible to the Patients.
11. Any marks, bruises, wounds, sores, local paint, evidence of disease of any kind, complained of by the Patients, or noticed by an Attendant during any of the bathing operations are to be immediately reported to the Medical Superintendent or one of the Medical Officers, and also to be entered in the Daily Report.
12. Any deficiency in the supply of warm water, soap, towels, etc., is to be reported to the Chief Attendant, and entered in the Daily Report to the Manager.
13. The Attendants are to bear in mind that, except under Medical Order, the Baths are to be employed solely for the purposes of cleanliness
14. Cold Baths, and enforced Shower Baths are never to be employed except under Medical Order, and then only in the presence of one of the Officers. All Shower Baths with doors must be kept locked, and the keys kept in the Chief Attendant's Office. Such Patients as so desire, and have received permission from the Medical Superintendent, or one of the Medical Officers, may be allowed to use the Open Shower Bath; but an attendant must always be present.
15. It is the duty of the Chief Attendant to be present, at all Baths employed under Medical Order, and to take care that the duration does not exceed the time specified in such Order. He is also to supervise the whole of the ordinary bathing operations, to ascertain that the Rules are rightly carried out, and to report to the Medical Superintendent every infringement that may come to his knowledge.

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[171] 5/5876-5877.

Canberra Escapees from Kenmore, 1925-51

Four male Canberra inmates attempted escape. Ivan Klima, a Displaced Person, was believed to suffer from 'delusions of being watched by hostile elements (mostly political)' and was diagnosed with schizophrenia. He had no family members in Australia. Klima was sent to Kenmore after a suicide attempt. Based on the interpreting efforts of a nurse, his case notes record – 'mentions he can hear voices. He is frightened.' Klima was regarded suitable for labour on Kenmore's grounds. Two years after his admission, he was declared Absent Without Leave from the outdoors-workers line up. He was never recaptured.

Leon Grabowsky, also a Displaced Person, was admitted to Kenmore after a suicide attempt. Grabowsky was diagnosed with Manic Depressive Psychosis, in particular, 'persecution mania'. His case notes state that work colleagues had 'baited' him by playing on his fears that he would be deported or gaoled. He managed to escape from the Occupational Room three months after admission and was never recaptured.

A third overseas born inmate, Avery Byrne was admitted to Kenmore as a voluntary patient but after a five month period his legal status was changed, and he became subject to an Order. Five months' later, Byrne complained about what he perceived to be civil rights abuses and asked to be sent to a general hospital. The diagnosis of paraphrenia, of suspiciousness and delusions of persecution, and of 'lacking insight into his condition' provide an explanation for why Byrne's complaint may have been recorded on his file, that is, as a manifestation of his delusional state. Three months later, Byrnes escaped. Details of Byrne's escape are not provided on his case notes apart from the notation that after several weeks he was recaptured and returned to Kenmore in an emaciated condition. The following describes Byrne's psychological condition after his return:

> The patient believes that he is wrongly detained; that he is unfairly treated; and that he has developed marked suspicions amounting to delusions of persecution. He is resentful and uncooperative and refuses to occupy himself in any way. He is regarded as an escapee, and is potentially suicidal and homicidal ...

Two years after his admission, Byrnes was deported to an asylum in the United Kingdom.

The fourth male escapee, David White, was admitted to Kenmore under police escort. From his case notes, it appears that his wife sought help from the medical profession in relieving her of a husband who she described as violent and a ‘sexual maniac’. White consistently complained that his wife was in conspiracy to have him committed on wrongful grounds. The Medical Superintendent, in a letter to Mrs White, wrote that ‘there is no doubt an element of truth underlying his delusions (of conspiracy)’. White escaped from Kenmore after eight months’ confinement: ‘did not return from pipelines this evening! Police notified.’ He was never recaptured.

One could speculate that those inmates who opposed their confinement on the grounds that they were unfairly institutionalised or those who had no trust in the therapeutic intents of the asylum or an acceptance of the asylum as an appropriate solution to their problems, were more likely to attempt to escape. A lack of English language literacy and a relative unfamiliarity with a new culture, compounded by experiences of war and displacement, exposure to community rejection and racial prejudice and discrimination, would have exacerbated non-English speaking inmates’ fears of and distress with institutional confinement. Not all non-English speaking inmates had access to a sympathetic or competent interpreter. It is interesting to note that all of these escapees are described as paranoid or suffering from delusions. Perhaps their symptoms of paranoia can be justified: as immigrants, Byrne, Grabowsky and Klima were subject to deportation if their prognosis for recovery was not good. Grabowsky’s fear of deportation had already been used by work colleagues who taunted him. It would also have been understandable for Klima and Grabowsky, as Displaced Persons, to entertain ‘delusions’ of persecution.

Two Canberra women attempted to escape. Of these, one of them features in the escape entries of the Medical Journal. Jennifer Edwards escaped from Kenmore in the same year she was admitted to the asylum. There were no further details about her escape recorded in the Medical Journal and I was unable to locate her file in Kenmore’s archives. Edwards was recaptured and died in Kenmore sixty years later.[172] Judith Kirkpatrick made two escape attempts during her 12 year stay at Kenmore. During her first attempt Kirkpatrick was ‘recaptured in grounds – abusive and resistive’; and after her second attempt, ‘(t)ried to escape ... had crossed sports oval and was near the river before they reached her – resistive, struggling, with abusive language during return’.

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[172] This information was provided to me by one of her family members, who contacted me after my research was featured in *The Canberra Times*.

The Woman who was Tied to a Seat

Within the restraints section of the Medical Journals, one woman's name stands out because of the frequency with which it was entered over a period of more than 10 years. Based on the Medical Journal's interpretation of her behaviour, Rose was one of the most notorious and difficult women of Kenmore. She was not a Canberra inmate. Fuelled by curiosity and the desire to learn why she had been sent to Kenmore, I located her name in the Admissions Register. She was admitted by Request in February in the 1920s. At the time of her admission, Rose was aged in her thirties, married with one child, and her occupation is listed as 'domestic duties'. She was described as suffering from acute melancholia brought on by childbirth.

One month after her arrival, Rose was placed in a camisole for seven days. The reason provided for her restraint was 'suicidal' behaviour. For the remainder of the year, Rose was placed under restraint every week apart from the month of July. Techniques of restraint included the camisole or the seclusion room. By September, however, the most common technique for restraining Rose had begun to be implemented: she was tied to a seat. In her second year at Kenmore, Rose spent every day under restraint. Her third year in asylum care was spent tied to a seat.

During Rose's stay, menstruating women were not provided with sanitary napkins.[173] I tried to imagine what it would have been like, tied to a seat while menstruating in the middle of winter, wearing a minimum of clothing in an

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[173] Personal communication with a nurse who worked in Kenmore in the Herd Care era. Based on information from oral history interviews and reflections of an administrator with the New Zealand Department of Mental Health, Kate Prebble notes that: 'nurses had to "make do" to provide sanitary pads for their patients. They were one of many things that the hospitals were short of. I understand that pre-WWII, nurses cut up and washed rags for female patients. During the War, supplies were so short, that many patients went without panties as well as without sanitary supplies. Shortages continued afterwards. I have heard accounts as late as 1960 of hospitals being very restrictive about their supplies of sanitary pads. One nurse described having to go to the matron's office daily to collect the one packet of pads to supply 150 patients in the "refractory ward". In that hospital, they often ran out of linen, toilet paper and sanitary pads. ... nurses' stories often mention the problem of dealing with very disturbed, menstruating women in the years before the introduction of neuroleptic medications. Nurses often felt that their only option was to keep the woman in isolation and bath them as often as needed' (personal communication). The lack of provision of female sanitary products was therefore not confined to Kenmore. Janet Frame describes her experience of institutionalisation in New Zealand as follows: 'I dreaded every month when I would have to ask for sanitary towels which were supplied by the hospital, for one or twice I was refused them …' (Frame 1961:83-84). This neglect of appropriate feminine products for women is firstly, a resource issue and secondly, also connected to the view that certain categories of women are unable or unwilling to use these products appropriately.

inadequately heated room. Or, menstruating while tied to a seat in the exercise yard. Rose would not have been able to keep warm during the winter months by exercising in the yard. In Kenmore's rural setting, menstrual blood would have attracted flies during the warmer months, but Rose would not have been able to brush them away. In an earlier century and on another continent, Haslam also reflects on the impact of a restraint upon the asylum inmate:

> It will readily be seen, when a patient is compacted in this instrument of restraint, that he is unable to feed himself, and also prevented from wiping the mucus from his nose as it accumulates, and which, if long continued, would render him a driveller. He cannot assist himself in his necessary evacuations, and thereby is induced to acquire uncleanly habits. He is incapable of scratching to appease any irritation – If, in the warm season, flies annoy him, he cannot drive them away, and if, from the negligence of the keeper, his person should be infested with other insects, he must submit to their painful vexation ... (Haslam 1975[a]:105)

In September of her fourth year, Rose's name disappears from the Medical Journal for a period which lasted for ten months. In July of the following year, she reappears and is placed under restraint for the remainder of the year. In her sixth year, Rose spends the entire year tied to a seat. Her physical restraint continued throughout her seventh year until September, when reference to her name disappears from the Medical Journal.

In August of the eighth year of her asylum confinement, Rose makes another appearance: for seven days a week over a ten week period, she is placed in either a muff or in a camisole. And then, once again, her name vanishes until the mid 1930s, when she spends three hours in seclusion. In 1936 she makes three appearances. These three entries refer to seclusion due to medical treatment for her legs. It was probably not unexpected that by this stage, Rose's legs would need medical treatment, after having been tied to a seat for almost a decade. In 1938 she makes her last appearance, 60 hours in a week for an indecipherable reason. After that entry, Rose's name no longer appears in the Medical Journal.

Rose stayed at Kenmore until its closure in 1942 when she, along with the entire inmate population, were evacuated and transported by double-decker buses to metropolitan and rural mental hospitals in New South Wales. Based on admissions register entries that recommenced in 1946, it appears that Rose never returned to Kenmore. What happened to her after she left its grounds in 1942 remains a mystery. I was unable to locate her file in Kenmore's Medical Records, presumably because it was shipped out, along with her, to another mental hospital in that year. She was 50 years old when she was transported to another institution. She had been an inmate of Kenmore for more than 15 years.

From the distance of time and space, it is difficult to establish why Rose was tied to a seat, placed in a camisole, or in seclusion for so many years. The reasons provided for restraining Rose indicate that her behaviour had changed, from ‘suicidal’ to ‘restless, out of bed’, ‘restless, destructive’, ‘violent’, ‘striking others’, ‘troublesome’, ‘grabbing others’, to ‘destructive’ acts. It was mainly because of her ‘destructive’ behaviour that Rose was placed under restraint. These Medical Journal entries suggest there was a mental deterioration in Rose after her admission to Kenmore. How should this deterioration be interpreted? Was it symptomatic of her descent into madness or as a form of resistance against her confinement? And then there are the years where her absence from the Journal is noticeable. How should this absence be interpreted? Was it an administrative oversight that kept her name from the Medical Journal or a change in staff responses to and treatment of her behaviour? Had her mental condition improved or was Rose’s spirit of resistance finally broken? Had she finally slipped into another kind of insanity or was she finally beginning to recover her reason? These are some of the questions arising out of Rose’s presence in the medical records, most of which will remain unanswered.