

A History of General Hospital Psychiatry in New South Wales

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*This is to certify that to the best of my knowledge, the content of this thesis is my own work.
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the assistance received in preparing this thesis and sources have been acknowledged.*

Signature

Name Richard Trathen White

This research project and the resultant dissertation are dedicated to the memory of Stephanie White (23.9.1971—11.9.1978) and the memory of Thomas Trathen White (7.2.1970 —17.4.1999).

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If I attempted to name all the members of the psychiatric fraternity who assisted me in this project between 2015 and 2022, I would probably forget to name others. Thank you all.

None of the above persons share responsibility for any of the opinions that I express or share responsibility for any misinterpretations or errors that might be found in this dissertation.

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Abstract

This dissertation offers a narrative account of the evolution of psychiatric services in the general hospitals of New South Wales (NSW) and then compares that account with published accounts concerning the evolution of psychiatric services in the United Kingdom (UK) and the United States of America (USA). At the start of the twentieth century, to improve the early identification and treatment of mental symptoms and to prevent their advancement to overt insanity, some leading psychiatrists proposed that persons who had incipient mental disorders and who wished to avoid legal certification to mental hospitals, should be admitted to general hospitals.

It will be demonstrated in this dissertation that, in NSW, between 1900 and 1960, psychiatry gained a small but significant foothold in the general hospitals. The advent of powerful new biological treatments for psychosis between 1938 and 1955, made possible the commencement of a second phase of general hospital psychiatry (GHP) in the 1960s, during which there was a massive migration of acute psychiatric services into the general hospitals. In the 1970s, public psychiatric services in NSW split into community-oriented services and consultation-liaison services, each of which had a secure base in the general hospitals.

The evolution of GHP followed similar but non-identical pathways in NSW, in the UK, and in the USA. The pathway adopted in NSW was initially like that followed in the UK but started to diverge from it after 1948. After 1960, psychiatry in NSW became even less reliant on British influences and more open to ideas from the USA concerning preventive psychiatry, community psychiatry and consultation-liaison psychiatry. By 1994, psychiatric services in NSW were following a trajectory that was determined by local experience and expertise and were no longer greatly dependent on influences beyond the Australian shores.

Introduction

In this dissertation, the term ‘general hospital psychiatry’ (GHP) refers to psychiatry that is practiced in general hospitals. ‘The era of general hospital psychiatry’ refers to the period during which mental health professionals, and the psychiatric services that they provided, migrated from mental hospitals into general hospitals. In anglophone jurisdictions that era can be usefully divided into two phases which commenced, respectively, in the late nineteenth century and close to 1960. In New South Wales (NSW) that era commenced in 1898, was well advanced by 1994, and, in 2022, appears to be nearing completion. The first phase of the era of general hospital psychiatry began in NSW in 1898 with the appointment of the second Inspector-General of the Insane for New South Wales, Dr Eric Sinclair. Sinclair adopted strategies that would make it possible for certain individuals who had mental symptoms to receive professional assessment and treatment close to the onset of those symptoms, when commitment to a mental hospital as an insane person would not have been contemplated and would not have been legally possible. During a career that spanned twenty-seven years, he was responsible for several major advances in the psychiatric services, including the establishment of a foothold for psychiatry in the general hospitals of NSW. It should be noted that Sinclair did not prophesize that mental hospitals were destined to lose their role as the principal institutions for the management of mental illnesses or that they would ever face closure.

Between 1938 and 1955, the advent of antipsychotic agents in NSW led to the second phase of GHP because it then became possible to manage persons who had severe mental disorders in general hospitals. During the second phase of GHP, which commenced close to 1961, there was a massive migration of mental health professionals from mental hospitals into general hospitals. By 1994, more than half of the government-funded acute care beds available for

psychiatric admissions in New South Wales were in general hospitals and many of the beds in the mental hospitals had disappeared.

Recurrent themes in narrative accounts of the history of psychiatry

In narrative accounts of the history of the development of psychiatric services in industrially advanced countries, five themes usually emerge. Those are themes of *care*, *treatment*, *neglect*, *control* and *mastery*. The governments of those countries invariably required that mentally ill persons within their midst must be *controlled* because they were regarded as potentially destructive to public order, to other persons, to property and to themselves. In modern societies, where insanity is a health issue rather than an issue of malevolence or animism, it is usually agreed that mentally ill persons are entitled to *care* and to *therapy*. When the mentally ill in those societies receive insufficient *care* or *therapy*, we often find agitation for change focussed on a discourse of *neglect*. When efforts to improve the fate of the mentally ill are successful, the authors of historical accounts will often emphasize the *mastery* of adversity. *Mastery*, here, is linked to the leadership provided by certain individuals in those societies—usually social reformers, politicians or medical practitioners. These themes are common to the history of psychiatric services in industrially advanced nations, regardless of the exact jurisdiction. The emphasis placed on each theme, and the balance between these themes, will vary from country to country and according to the period of interest. In the present dissertation there will be special attention to three additional themes: *inheritance*, *modification* and *innovation*. The historical research project that led to the writing of this dissertation was focussed on the ways in which ideas from other countries—especially ideas from the United Kingdom (UK) and the United States of America (USA)—have influenced the development of psychiatric services in New South Wales. Because the entity called New South Wales came into existence as a British penal colony and

remained part of the British Empire for more than a century, it was inevitable that NSW would *inherit* British ideas about governance, laws, administration, science, medicine, psychiatry and psychiatric services. Those ideas would require *modification* to find practical application in the antipodean physical and social environment of NSW, which would require the creative process of *innovation*. With the passage of many decades, the developing society in NSW would look to other countries for newer ideas. It would transpire that the USA—an extraordinary powerhouse of new ideas— would become a source of inspiration concerning psychiatric innovations and psychiatric services. Those ideas would, in turn, require *modification* to suit the local circumstances.

The contention that will be supported in this dissertation

In this dissertation, I will argue that the historical development of general hospital psychiatry in New South Wales initially followed a pattern that had been set in Britain but was influenced by local factors, which included the large distances between centres of population and the necessity for local modifications of British systems of governance and administration.

During the first phase of the era of general hospital psychiatry, between 1898 and 1961, psychiatry established a small but important foothold in the general hospitals of New South Wales. However, after 1948 the trajectory of psychiatric services in New South Wales started to depart from the one that was being adopted in Britain. After 1948 the characteristics of the government funded and the privately funded psychiatric services of New South Wales began to differ, in significant respects, from their counterparts in the UK and the USA.

In the late 1950s, the availability of powerful new treatments for severe mental disorders allowed the creation of new policies concerning the management of those disorders. These

developments made possible, in 1961, the commencement of the second phase of the era of general hospital psychiatry in NSW, during which acute psychiatric services migrated into the general hospitals. Also, during the 1960s, the arrival of new ideas from the United States of America concerning community-focussed psychiatry and consultation-liaison psychiatry fostered major changes in the psychiatric services in NSW.

By 1994 the acute psychiatric services of NSW had effectively subdivided into integrated community-oriented psychiatric services and consultation-liaison services. The mental hospitals had lost most of their acute psychiatric services but had retained some of their other clinical functions. In 1994, psychiatric services in New South Wales were following a trajectory that was determined by local experience and expertise and were developing with far less ongoing influence from beyond the shores of Australia.

A guide to the chapters of this dissertation

There are excellent narrative accounts of the development of general hospital psychiatry (GHP) in Britain and in the United States. These accounts are summarised in *Chapter One: Literature review: The evolution of general hospital psychiatry in the United Kingdom and in the United States of America. Chapter Two: The evolution of general hospital psychiatry in New South Wales and in other parts of Australia* will clearly demonstrate that no comprehensive account of the development of GHP in an Australian state or territory has yet been published and that little attention has been paid to the history of psychiatry in Australian general hospitals. This might surprise historians of psychiatry because, during the second half of the twentieth century, the migration of psychiatry from the mental hospitals into the general hospitals has led to enormous changes in most aspects of psychiatric services. It seems important to know why, in the states and territories of Australia, that migration

happened, how it happened and to understand all its consequences. One cannot assume that the developmental history of GHP in NSW simply mimicked the developmental history of GHP in Britain or in the USA. In fact, that is not what happened.

I intend that that, by drawing on historical records, I will be able to create a narrative account of the evolution of general hospital psychiatry in NSW. That account should be a useful contribution to the global literature concerning the evolution of general hospital psychiatry and address a significant gap in the record concerning an important phase in the development of Australian psychiatry.

In this dissertation there are a total of thirteen chapters. They deal with three concurrent processes: a narrative concerning developments in psychiatry and in psychiatric services in NSW, the contextualisation of that narrative with respect to developments in general hospital psychiatry in the UK and the USA and, thirdly, my defence of the contention that I stated in earlier paragraphs of this Introduction. Related to those processes there are two chapters that review the literature concerning general hospital psychiatry, five narrative chapters, five contextual chapters, and a chapter that summarises the defence of the original contention and will conclude this dissertation. The five narrative chapters are arranged in chronological sequence but are often separated by contextual chapters. *Chapter Three* is a narrative chapter that describes the development of hospital and medical services in NSW between 1788 and 1961. During those one hundred and seventy-three years there was a near-absolute division between non-psychiatric and psychiatric services. In 1961 the Government of NSW started the processes by which that division would be abolished and those services would be amalgamated. There are four narrative chapters concerning the development of psychiatric services in NSW between 1868 and 1994. The first of these is *Chapter Five: Lunacy services*

in New South Wales in the late nineteenth century which offers the reader an account of alienism in NSW before psychiatry found any place in the general hospitals. Narrative accounts of the era of general hospital psychiatry commence in *Chapter Seven: Under the leadership of Eric Sinclair (1898 to 1925) psychiatric services enter the general hospitals of NSW* and continue in *Chapter Eight: Psychiatry in the doldrums (1925 to 1961)* and in *Chapter Ten: A renaissance in psychiatry in New South Wales (1961 to 1994)*.

There are five contextual chapters, the first of which is *Chapter Four: Moral treatment and medical therapeutics during the asylum era*. The other contextual chapters are *Chapter Six: New proposals for psychiatry for a new century*, *Chapter Nine: The impact of new treatments on psychiatric services*, *Chapter Eleven: The impact of psychiatry on general medicine: Maddison and Pilowsky* and *Chapter Twelve: The birth and growth of consultation-liaison psychiatry in New South Wales*.

The author's opinions and observations concerning medical practitioners and academics as historians of psychiatry

Historians of psychiatry mostly come from two professional backgrounds: they either initially trained to be medical practitioners or to be historians, sociologists or philosophers. The earliest historians of psychiatric services were usually medical practitioners. The main themes which ran through their accounts of the history of psychiatry tended to be those of *care*, and of *therapy*. Historians from medical backgrounds usually emphasized advances in therapy, the benevolent attitudes of physicians and the frustratingly long and slow progress towards the *mastery* of insanity by medical science. The earliest of those medically educated historians seldom underwent rigorous academic training in historiography. Their accounts gave a perspective of the history of psychiatry 'from the top down' because they reflected the

values and perspectives of medical practitioners. Those accounts mostly went unchallenged until the middle of the twentieth century when academically trained historians and sociologists began to criticise medical clinician's accounts of history and to offer new perspectives.

It has transpired that most of the published accounts of the global evolution of GHP pertain to the USA and to the UK, and that most of those accounts were written by psychiatrists. That much will be evident to the readers of *Chapter One* and *Chapter Two*, which offer the reader reviews of the published literature concerning general hospital psychiatry in the UK, the USA and Australia. Even the best-known academic historians of psychiatry, including Porter in the UK, Rosenberg in the USA and Garton and Colborne in Australia, have written very little about what actually happened when mental health professionals entered the general hospitals. Notable but uncommon exceptions to the latter pattern were contributions by the US sociologist Lorna Bachrach, and the British health planners GF Rehin and FM Martin.

Academically trained historians, sociologists and philosophers began to publish accounts of the history of psychiatry during the 1970s. They often emphasized the perspectives and the experiences of patients. This approach to historiography became known as 'the social history of psychiatry.' The themes of these narratives included *control, care, therapy* and *neglect*. Academic historians are probably more likely than psychiatrists to express doubts about the motives of governments and of psychiatrists and about the quality of the *care* and *therapy* offered to psychiatric patients. They tend to pay more attention than psychiatrist-historians to non-medical factors, which include social, cultural and economic considerations. The methodology of academic historians relies heavily on their ability to gain access to documents that were written in earlier decades. This methodology proved to be very useful

when applied to the history of asylum psychiatry because there was copious documentation surrounding the legal certification and the management of persons who were confined in mental hospitals. Professional historians were able to examine asylum records, legal records, case notes and personal correspondence relating to large numbers of patients who had been certified as insane and who remained in mental hospitals for many months or for years.

However, this methodology has far less potential for success when employed in general hospitals. This is because the documentation of psychiatric management and treatment processes in the general hospitals is far less standardised, far less comprehensive and sometimes more difficult to decipher than documentation concerning patients in the mental hospitals. The duration of the admission of patients to general hospital psychiatric units during the second half of the twentieth century was usually less than six weeks and, by the twenty-first century many general hospital psychiatric admissions lasted less than seven days. The records pertaining to those admissions are often brief and lack the details which might be sought by historians. Another problem for historians of psychiatry is that most psychiatric treatments can be provided without the necessity for admission to a hospital. To overcome these difficulties, many historians began to utilise oral history methodologies. They then encountered new problems. In the twenty-first century, patients who undergo psychiatric assessment and management might refuse access to their records or decline invitations to be interviewed. Despite these difficulties historians are currently studying the history of Australian community mental health services by the employment of oral history methodologies. If those studies bear fruit, it is predictable that oral historians of psychiatry might eventually turn their attention to the evolution of general hospital psychiatric services.

The multiple roles of the author as a psychiatrist, as a participant-observer and as a researcher concerning the history of psychiatry

In March 2015, at the commencement of this research project, I was acutely aware that I must set certain limits. I was tempted to examine the history of GHP in other jurisdictions such as the other States of Australia or the nations of Canada or New Zealand, but I quickly concluded that I did not have enough time, or other resources, to go beyond the jurisdictional boundaries of New South Wales. Moreover, I would try to confine my project to an examination of adult psychiatric services. The project would not include an examination of psychiatric services for cases of developmental disability, or of children or of persons over the age of 65. It would not deal in any detail with the history of the psychiatric services provided to indigenous populations. Nor would it focus on the recorded experiences of patients who suffered from mental disorders.

Between 1959 and 2017, I was a participant-observer in medicine and in psychiatry, firstly as a medical student, then as a young medical graduate, and then as a trainee psychiatrist. I qualified as a psychiatrist in 1970. Between 1970 and 1975 I was a consultant psychiatrist and sometimes a clinical team-leader in the psychiatric service of the State of New South Wales. Most of that work was in mental hospitals but a little of it was by my attendance at general hospital outpatient clinics and at community mental health centres. Between 1975 and 2013, I was employed in general hospitals, mostly as a senior staff specialist psychiatrist. For several years I also worked in private practice. Between 1987 and 1996, I became increasingly involved in psychiatric administration in the Department of Psychiatry at the Royal Prince Alfred Hospital. Details of my professional life are contained in a Professional Memoir which is attached as an appendix to this dissertation. Because I was a participant-

observer of many of the events that I describe, this dissertation differs from accounts provided by non-psychiatrist historians.

There are hazards confronting any psychiatrist who intends to research episodes in the history of psychiatry. In the 1960s, the philosopher and historian of ideas, Michel Foucault, offered a revisionist analysis of the asylum era that was clearly at odds with earlier accounts of the history of psychiatry.¹ The sociologist Andrew Scull has criticised the quality of Foucault's historiography but stated that he shared Foucault's qualms about the worth of many histories of psychiatry that had been offered by psychiatrist-historians.² In 1991 Scull wrote: 'Until the last two decades, psychiatric history was written primarily by amateurs. And a peculiar group of amateurs at that—psychiatrists themselves.'² Scull acknowledged the lasting significance of contributions to the history of psychiatry by a few psychiatrists, among them Richard Hunter, Ida Macalpine and William Parry-Jones, but Scull added that even the works of those authors had 'elements of partiality'. Scull then added:

In the usual case, however, the resulting distortions have seriously compromised the scholarly accounts offered—creating versions of the past that serve (in ways obscured by their authors) to legitimate the profession's present-day activities; or that represent a harmless form of antiquarianism but largely fail to satisfy the elementary canons of good historiography.²

More recently, in the *Times Literary Supplement*, Scull was much kinder to psychiatrist-historians and praised some of the work of:

... clinician-historians such as Joel Braslow, German Berrios, David Healy and George Makari, who combined psychiatric expertise and serious historical

scholarship in ways that greatly enriched the sophistication and the range of questions that come to mark work in the field.³

The academically trained historians always encouraged an examination of the perspective of those who suffered from insanity, rather than from those who treated it.⁴ They encouraged new perspectives and new research; this was good for the historiography of psychiatry. When reading Foucault and Scull, a seasoned psychiatrist like myself might feel defensive but would be forced to acknowledge that the new critiques of accounts of the history of psychiatry by academically trained historians were timely and valid.⁵ My own position concerning perceived tensions between the efforts of psychiatrists as historians and the efforts of academically trained historians is that both approaches provide valid insights and that neither perspective should be ignored or avoided.

The British psychiatrist-historians, Drs Allan Beveridge and Claire Hilton, have offered cautionary tales, observations and guidelines for the benefit of psychiatrists who wish to contribute to the historiography of psychiatry.^{6,7} Beveridge warned against the construction of ‘Whiggish histories’—narratives of benign progress in psychiatry governed by ‘the notion of a "Great Man" who improves the lot of the mad by his sole efforts.’⁶ Beveridge commented that such ‘Whiggish histories’ ignore social, cultural and political influences and were: ‘...seen by non-medical people as complacent, self-congratulatory and serving to legitimise psychiatry’s present.’ Academic historians, says Beveridge, are alarmed by the following shortcomings of psychiatrist-historians: being unreflective about the nature of psychiatry; assuming that their goals are all noble and humanitarian; assuming that their diagnoses and terminology are appropriate for differing historical eras; assuming that mental

illnesses do not change in various times and places; overvaluing retrospective diagnosis and for ignoring cultural processes.⁶

In March 2018, Dr Claire Hilton conducted a workshop on behalf the Royal College of Psychiatrists for the benefit of psychiatrists who wished to study and to write about the history of psychiatry.⁷ During that workshop, and in a related paper, she analysed problems that stemmed from the fact that psychiatrists are trained to use approaches to historiography that differ significantly from those of professional historians.^{7,8}

Clinical history-taking gathers information from the past to understand a patient's illness in the present to plan future treatment. A scientific literature review is undertaken to justify a future scientific or clinical research proposal. ... A historian, by contrast, aims to understand the past in its own context, not directly related to present or future objectives or through the eye of hindsight.⁸

During the 2018 workshop, Hilton emphasised the need for contextualisation, objectivity and the avoidance of the following traps: retrospective interpretation; retrospective diagnosis and interpretation of symptoms and reliance on institutional memory and linear interpretations. She advised the novice psychiatrist-historian to anticipate a time lag between events or scientific discoveries and resultant changes in the attitudes of a society. She warned that, in historical narrative, the use of terminology appropriate to an earlier era, for example 'idiot' or 'lunacy', may cause offence in another. Hilton's injunctions included: 'Use historical material to provoke thought, not to answer questions,' and 'Don't try to explain the present by using the past'.⁷ By respecting the advice of these two British mentors I hope to navigate the difficult terrain that awaits a psychiatrist-historian.

My research project and the resultant dissertation are largely about the development of ideas concerning the management of insanity in NSW and concerning various attempts to put those ideas into practice. Those ideas belonged to psychiatrists, to general physicians, to psychiatric administrators, and to the governing and intellectual cadres. In other words, the account that I provide in this dissertation is far more ‘from the top down’ than an exercise in the social history of psychiatry. Some readers may be disappointed that the experiences and opinions of psychiatric patients are not featured in this dissertation. However, the task of collecting those data was well beyond my resources, including the time available to me for the completion of this project. Some readers will detect Whiggish tendencies in my account of the history of psychiatry. It will be obvious to any reader that I greatly admire several of the psychiatrist-administrators who I describe in this dissertation. It will also be obvious that—

notwithstanding my frank acknowledgement that psychiatrists have been responsible for many ghastly practices—I believe that, during the last two hundred years, psychiatry has helped far more of its clientele than it has hindered. I believe this has been especially true since the 1960s. To state that psychiatry has, in 2022, more to offer its patients than it did in 1898, is only to state an historical fact.

I wish to note a hazard that was not emphasised by Beveridge but was touched on by Hilton. In the years between 2015 and 2017, I was both a practicing psychiatrist and a researcher of the history of psychiatry. In those years I was sometimes asked to discuss links between my studies and twenty-first century controversies, including arguments about deinstitutionalisation, the persistence of stand-alone mental hospitals and the wrongful allocation of psychiatric resources. This troubled and distracted me from my historical research efforts. I felt that, while I was conducting research about psychiatry in remote decades, it was important that I should attempt to understand and to empathise with the

thoughts and the attitudes of persons who lived during those decades—including the thoughts and attitudes of psychiatrists. Yet those persons would certainly not have been ruminating on problems that would only come to light in the twenty-first century. If I focussed my attention on issues in the twenty-first century, I might find it hard to approach the mindsets of persons who lived in earlier centuries.

Having offered the above comments and concessions, I propose that my professional experience in medicine and in psychiatry should be regarded as an asset that—if I use them appropriately—should enhance the quality of my research and the quality of this dissertation. I claim that my experiences as a psychiatrist should provide three advantages:

First, because of my training and experience as a psychiatrist, I have some knowledge concerning mental illness and its management that might not be easily acquired without clinical training and experience in psychiatry at an undergraduate and at a postgraduate level. Among those experiences, I was, for close to three decades, either a clinical lecturer or a clinical senior lecturer in psychiatry at the University of Sydney. I was also a teacher and a supervisor of trainee psychiatrists. Consequently, I claim to be conversant with the published research concerning the efficacy, effectiveness and the unwanted effects of psychiatric treatments. Secondly, because I have had the benefit of more than four decades of engagement with patients, their families and their therapists, I have some understanding and insight concerning the habitual thought processes and attitudes of all of those parties. Thirdly, I am able provide some historical data directly from my own recollections and from my own notes and diaries.

I employ a first person or second person narrative modality in this *Introduction*. In the chapters of this dissertation, I mostly employ third person narration but sometimes revert to first person narrative when I add brief comments about my own personal experiences and observations. I usually do that in square brackets, thus: [].

I hope that the reader of the thirteen chapters of this dissertation will conclude that I have adequately defended the contention that I recorded in the early pages of this *Introduction*. I intend that the appendices to this dissertation should be regarded as of a supplementary nature. The appendices are primarily intended to help readers who wish to know more about my professional background and the influences on my thinking. I feel that *Appendix One: Methodology* and *Appendix Two: Professional Memoir* might be recruited to support the argumentation that is provided by conventional scholarship in the thirteen chapters of the dissertation, but that those appendices are not essential for the defence of the contention that is recorded on the second and third pages of this *Introduction*.

Ethical considerations

Before embarking on this research project, I examined the website of the University of Sydney for its position on ‘Research Integrity and Ethics’. I concluded that no aspect of my research project required the formal approval of the University of Sydney Human Research Ethics Committees (HECs). I also studied the ‘National Statement on Ethical Conduct on Human Research’ (2007). I wished to be certain that there were no ethical impediments to any aspect of this research project, but I could find none. It was never my plan to access any case records or other documents concerning individuals who had previously suffered from a mental disorder, whether in the nineteenth, twentieth or twenty-first centuries. In this dissertation I do not refer to, or quote, any of my former patients.

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Chapter One

Literature review: The evolution of general hospital psychiatry in the United Kingdom and in the United States of America

1.1 Introduction

Chapter One provides an overview of the global literature concerning general hospital psychiatry. Nearly all of that literature deals with the evolution of general hospital psychiatry in the United Kingdom and in the United States. Because the jurisdiction of New South Wales came into existence as a penal colony of Britain and would remain part of the British Empire until the twentieth century, and because it was inevitable that ideas from the United Kingdom and the United States would influence the development of psychiatric services of the Australian colonies, states and territories, a review of the development of psychiatric services in those two anglophone countries is a necessary precursor to an examination of the evolution of general hospital psychiatry in any of the colonies, states or territories of Australia—including New South Wales.

1.2 Comprehensive accounts of the evolution of general hospital psychiatry in the United Kingdom

There are two authoritative and frequently cited accounts of the history of general hospital psychiatry (GHP) in Britain.^{1,2} These accounts, by the academic psychiatrists, Richard Mayou and Hugh Freeman, are relatively brief but they are comprehensive and very useful. In his 1989 account concerning the development of GHP in the United Kingdom (UK), Richard Mayou considered two major themes: the treatment of serious mental illness within general hospitals and the management of ‘emotional and functional somatic symptoms,

which have only recently been seen as part of psychiatry'.¹ Nearly two decades later Mayou updated that account in a chapter in the *Handbook of Liaison Psychiatry* (2007).² Hugh Freeman's account of the history of general hospital psychiatry in Britain is consistent with the accounts provided by Mayou but pay more attention to developments after 1980, and to the fate of chronically and recurrently mentally ill persons in the UK.³ In 1996 Freeman published an account of the evolution of community psychiatry in Britain that nicely complemented his paper on the evolution of general hospital psychiatry.⁴

1.3 The management of serious mental illness in the United Kingdom in the nineteenth century

Increasingly throughout the nineteenth century, when persons became insane, they were usually managed by processes of legal certification of insanity and committal to mental hospitals. The alienists, and their asylums, took responsibility for the control and the care of cases of manifest insanity—which we now call psychosis—and showed much less interest in other psychiatric disorders.¹⁻³ Prior to 1890 most voluntary hospitals in the United Kingdom—hospitals which we now call general hospitals—did not admit or treat persons who were obviously insane. They did, however, admit and treat those patients who suffered from delirium associated with physical illness, and some voluntary hospitals even had special wards or private rooms for patients who were delirious, demented or suffering from puerperal fever.⁵ Voluntary hospitals usually also accepted responsibility for the care of patients who manifested behavioural and emotional problems that included hypochondriasis, 'hysteria' and 'functional complaints', dyspepsia, pain problems and neurasthenia. The symptoms and signs exhibited by those patients were very different from those of cases who were managed by alienists in private or public mental asylums; their behaviour was not usually disruptive to other patients or to the orderly functioning of the medical wards of general hospitals. Those

lesser mental disorders were often managed by practitioners in the emerging specialty of neurology. Voluntary hospitals also took some responsibility for the care of a diverse mix of problems that included anorexia nervosa and alcohol-related problems like delirium tremens. Cases of attempted suicide were routinely accepted for management by general hospitals until they had recovered from the physical effects of overdoses of drugs or from self-inflicted trauma, but they rarely received concomitant psychological assistance.⁵

Near the end of the nineteenth century, the leaders of the British psychiatric profession believed that persons who showed signs of ‘incipient mental disorder’ should be assessed and treated—as a matter of urgency—before their symptoms worsened and they became overtly insane. At that time psychiatrists universally believed, as they still do in the twenty-first century, that the promptest treatment of insanity would bring the best outcomes and that delays in treatment would lead to chronic mental illness. In order to encourage the rapid assessment and treatment of persons who had early mental symptoms, some alienists allowed voluntary admission to their asylums, but in so doing they ran the risk of breaking the laws or deviating from the practices of the jurisdictions in which they worked.

In 1902 the issue of the management of incipient insanity was of great interest to the medical profession and was discussed and debated at length during professional meetings in Edinburgh and in Liverpool. The first of those meetings in Britain, in February 1902, was convened by the Edinburgh Medico-Chirurgical Society at the Royal Infirmary of Edinburgh to discuss ‘The Treatment and Teaching of Incipient and Transitory Mental Disorders’.⁶ Later in that year the same topic was debated at the Annual Meeting of the Medico-Psychological Association in Liverpool.⁷ The latter meeting was attended by some of the participants in the Edinburgh meeting. Within the psychiatric profession of the UK a consensus was developing

that most cases of mental disorder should be assessed and managed in a ward setting before they were certified and sent to an asylum. There was much debate, however, about the most appropriate site for that expert assessment. Should cases of incipient mental disorder be admitted into a ward in a general hospital? If not, should those cases be assessed at a reception centre well away from, or adjacent to, a mental hospital? Some participants in those debates favoured admission to general hospitals, where, they argued, those patients would receive the best possible medical and psychiatric assessment and management and that this process would ensure that some patients would avoid the stigma associated with admission to a mental asylum. Others argued that the use of reception houses linked to the mental hospitals would provide more specialised psychiatric and nursing assessment and care than would be possible in a general hospital. The debates at the British conferences in 1902 canvassed the full range of issues related to the management of incipient mental disorders.^{6,7} Those debates will be described in detail in *Chapter Six: New proposals for a new century*.

1.4 Psychiatry and the general hospitals in Britain, 1890 – 1945

Between 1890 and 1945, psychiatric services developed beyond British mental hospitals in five settings, ranging from general hospitals through to Poor Law institutions and out-patient clinics.⁸ The first of those settings was a ward in a general hospital in Scotland. In 1887 a general hospital psychiatric unit opened at the Barnhill Parochial Hospital in Glasgow. Dr John Carswell, the director of that ward, carried out many domiciliary visits and admitted 337 inpatients during the four years that ended in May 1893. Favourable results led Dr Carswell to conclude that ‘...all cases of mental disease’ should thenceforth be treated ‘in hospitals or reception centres before being sent to asylums.’⁸ In 1904 Dr Carswell was appointed at the new 240 bed Duke Street Hospital in Glasgow to manage a fifty-bed psychiatric observation ward.⁹ A small number of psychiatric wards were created in several British general hospitals,

but the majority were situated within Poor-Law institutions, the second key setting for the development of psychiatric services outside mental hospitals.⁹

Prior to the 1930s the parishes of Britain were responsible for the maintenance of poorhouses and workhouses. Many of the workhouses had infirmaries and those infirmaries often housed mentally ill persons. In the early 1900s mental observation wards were created in the workhouses to provide some initial assessment of mental symptoms prior to the triaging of cases of serious mental illness to the mental hospitals. These observation wards offered psychiatric services that were probably substandard but some, such as the one at the St Francis Hospital in Camberwell, which was later associated with the Maudsley Hospital and with Kings College Hospital, provided a satisfactory standard of management.⁹

The third setting for psychiatric services was the teaching hospital. One of the goals of the Board of Control for Lunacy and Mental Deficiency, which existed between 1913 and 1946, was to improve the psychiatric education of the whole of the medical profession. In 1918, the Board called for the establishment of teaching wards in general hospitals. The perceived need for improvement in the training of psychiatrists led to the foundation of the Maudsley Hospital, which opened as a postgraduate teaching centre in 1923. However, the Maudsley was not a general hospital. The first psychiatric ward in a general teaching hospital—a ward containing thirty-five beds—opened at Kings College Hospital before the Second World War under the direction of Professor Edward Mapother. This ward closed when Mapother retired in 1939. Because of his experience as director of that ward Mapother concluded that isolated psychiatric wards could not function effectively in general hospitals.⁹ However, plans persisted for a psychiatric unit of thirty-five beds in London at St George's Hospital, but those plans were abandoned because of the anticipated onset of the Second World War.

The fourth setting was the utilisation of beds for mental cases in the non-psychiatric wards of general hospitals. During the interwar years several hospitals allowed psychiatrists to admit patients to beds in medical wards. Guy's Hospital and the Middlesex Hospital each allocated six beds for psychiatric patients. At St Luke's Hospital, Dr Gilmour reported on the treatment of several cases of serious mental illness, each requiring about three months of inpatient care, a longer duration than was required for most medical or surgical patients.¹⁰ A new specialty of 'psychological medicine' arose in the neurology departments of some voluntary (general) hospitals.

The fifth setting for the development of psychiatric services beyond the mental hospitals was the establishment of out-patient clinics (OPDs) in general hospitals. Between 1890 and 1914 five of London's major general hospitals, several hospitals in regional England and one in Glasgow opened psychiatric OPD clinics. Many more opened after the War. Most OPDs were staffed by 'physicians in psychological medicine' but others were staffed by medical officers from the mental hospitals. The former often employed ideas derived from psychoanalysis. Most of the patients seen at these clinics had 'psychoneurotic problems'; few attendees had psychotic symptoms. During and after the War these clinics often adopted psychological approaches to the management of 'shell shock' in addition to a range of psychoanalytic techniques.¹⁰ In 1920 the Tavistock Clinic was created for similar purposes, but with an even stronger emphasis on psychoanalytic ideas, but the Clinic was not part of a general hospital.

The Mental Treatment Act of 1930 made it legally possible to treat psychiatric disorders in mental hospitals on a voluntary admission basis. This should have stimulated the mental

hospitals to engage more with adjacent communities but most mental hospitals failed to respond to the new opportunities offered to them by the Act. At the end of the 1930s, mental hospitals remained overcrowded, understaffed and still remote from the communities which they served and from general medical services. By 1942, however, the number of psychiatric OPD clinics had jumped from 29 to over 210. During the Second World War, a survey of psychiatric OPD clinics in England and Wales was conducted at the instigation of Professor Aubrey Lewis. It showed that 71 percent of OPD Clinics were located at general hospitals, 14.3 percent in municipal hospitals, 7.1 percent in mental hospitals and 7.6 percent in other places.¹¹

1.5 Psychiatry and the general hospitals in the UK: 1945 – 1962

During the Second World War the experiences of medical practitioners and psychologists in the management of psychiatric emergencies and in the treatment of non-psychotic conditions encouraged a certain optimism in those professions; the range of problems that could be considered ‘psychiatric’ was expanding rapidly and a series of new treatments appeared promising. Both psychological treatments and biological treatments, including electroconvulsive therapy (ECT), gained new credibility during the late 1930s and 1940s. Antipsychotic drugs became available in the mid 1950s and proved remarkably effective and useful in the management of the acute phases of severe mental disorders. Despite these promising developments, the introduction of the National Health Service, in 1948, actually led to a decline in the funding of mental health services relative to pre-war funding levels. Nine years later a Royal Commission (1957) recommended changes that would be incorporated in the Mental Health Act of 1959. This legislation coincided with government planning for increased capital spending on the mental health services. Yet by this time the morale of the staff of the mental hospitals had fallen to a new low. There were fewer skilled

staff working in the mental hospitals and the physical plant had continued to deteriorate, together with standards of patient care.¹²

With the mental hospitals in decline, Aubrey Lewis and many specialists in psychological medicine pressed for the acceptance of psychiatry as a major medical specialty with full representation in teaching hospitals and in large general hospitals. The bulk of the medical profession backed this initiative, but some mental hospital psychiatrists remained opposed to the transfer of any portion of the clinical management of their patients to the general hospitals. They argued that a far better course of action would be to renovate the mental hospitals and to improve the existing treatment programs that they were providing.

Between 1939 and 1960, both on their own initiative and following pressure from British educational bodies, the teaching hospitals began to provide better facilities for undergraduate psychiatric education. In 1944 a military facility for nervous disorders at Guy's Hospital was converted to create a new clinical unit called the York Clinic.¹³ In 1961, David Stafford-Clark gave a detailed account of the history and functioning of the York Clinic.¹³ The York Clinic had 45 psychiatric beds and several outpatient clinics. It also provided psychiatric consultation to the medical wards of Guy's Hospital. Similar units were created at St Thomas's, the Waterloo and the Atkinson Morley hospitals.

In 1939, when the Second World War broke out, there were only two university departments of psychiatry in Britain—one at Edinburgh and the other at the King's College, the Maudsley Hospital and the University of London. In the years following the War, between 1944 and 1960, academic departments of psychiatry were established in eight provincial medical schools. The inpatient units attached to those departments were small, typically containing

between fifteen and thirty beds. Debate ensued between the likes of Professor Aubrey Lewis at the Maudsley Hospital and Dr Desmond Curran, who was President of the Medico-Psychological Association, concerning the most appropriate patients for these academic departments. Those debates centred on ethical and educational issues. It was argued that inpatient services in teaching hospitals were behaving unethically when they refused the management of cases of severe mental illness and when they refused to accept local 'district' or 'catchment area' responsibility for psychiatric disorders. It was also argued that medical students should be exposed to the full range of psychiatric disorders rather than to the limited range of mental disorders then seen in the wards of a teaching hospital. These issues were only fully resolved when the administrative divide between teaching hospitals and district hospitals was abolished, at which point all the academic departments accepted their share of catchment area responsibilities.¹⁴

Institutional and geographic conflicts contributed to a slow and piecemeal development of general hospital psychiatric services in the UK. During and after the War there was much debate about the potential value of psychiatric inpatient units in non-teaching general hospitals. Those psychiatrists who championed these units pointed out that there were, by 1963, some 500 units of this kind in the United States and proposed that Britain follow the American example. Predictably, mental hospital psychiatrists responded that general hospitals would never be able to offer the multiple components of management that were available for seriously mentally ill patients in medium-term and long-term care in British mental hospitals. Differing policies were adopted in different regions of Britain according to varying levels of interest and support for the translocation of psychiatric services into the general hospitals. In 1948 the Manchester Regional Board rejected proposals for new mental hospitals and opted to develop psychiatric units in general hospitals. It was soon reported that

these initiatives were seeing good clinical and economic results, but these findings were disputed by psychiatrists from other parts of Britain.

The development of general hospital psychiatric services in the post-war decades was further slowed by repeated queries and concerns. There were persisting questions about the optimal number of beds in psychiatric units in general hospitals, about the optimal number of mental health clinicians to be employed to serve certain populations, and about whether those clinicians should be psychiatrists, psychologists, social workers, nurses, or other mental health professionals. Should the neuroses and milder forms of disturbance be accepted as a legitimate responsibility of the mental health services? There were also serious unanswered questions about the long-term care of chronically ill patients. In the UK, by 1960, persistent lack of funding was contributing to inadequate staff numbers and low standards of care. By that year, eighty-two general hospital inpatient units had been created in the UK, most of which were small.

1.6 The 1962 Hospital Plan

In 1961 the Minister for Health, Enoch Powell, announced that most of the psychiatric beds in the United Kingdom should be in the wards and wings of general hospitals. He looked forward to ‘...nothing less than the elimination of by far the greater part of this country’s mental hospitals as they exist today’.¹² This was a radical ambition. The 1962 Hospital Plan was created to pursue this goal, as well as to deal with problems that had resulted from decades of insufficient investment in mental health services, including the early years of the NHS. Primary responsibility for mental health care was clearly assigned to psychiatric centres that would be based in district hospitals. District hospitals were to become responsible for the provision of health care to well delineated geographic communities.¹² The

plan for the closure of Scottish mental hospitals allowed a more gradual process than that prescribed for England and Wales. For the existing health services the Hospital Plan for England and Wales had the potential for both benefits and risks. Benefits would include the ease of access by citizens to general hospital units, the availability of the general hospital's medical and other specialist services and the removal of the stigma associated with mental asylums and mental illness. There were potential risks associated, however, with the management of less cooperative, more disabled and long-stay psychiatric patients and with the creation of psychiatric facilities within general hospitals, where staff generally lacked familiarity with the needs of the mentally ill.¹²

In 1963 the health planners Rehin and Martin published an important critique of planning processes in which they condemned the absence of guidelines concerning the selection of patients for general hospital units. They also criticised the quality of government planning for the management of medium-stay and long-stay patients. They concluded that economic considerations contributed to the radical nature of the Hospital Plan: it was essential to find ways of modernising psychiatric services at the cheapest cost.¹⁵ In 1969, when Martin and Rehin again reviewed and commented on this subject, they suggested that it might never be possible to create a genuinely comprehensive psychiatric service in more than a minority of general hospitals.¹⁶ In 1972 the British historian of psychiatry, Kathleen Jones, argued that one danger facing the outcome of the Hospital Plan was that it would lead to two very separate and unevenly resourced psychiatric services – that mental hospitals would need to manage the most difficult clinical problems with fewer resources than general hospitals, with insufficient staff and with an inferior status in the eyes of the of the general public.¹⁷

The actual closure and rebuilding of the British psychiatric services were always much slower than Powell had predicted in 1961. By 1975 the Government had only succeeded in abolishing 20 of the 130 mental hospitals in England and Wales earmarked for closure. In the meantime, the mental hospitals continued to decline. By then, well-informed commentators were agreeing that neither the costs generated by the new mental health system nor the clinical effectiveness of the new general hospital inpatient units had been properly evaluated and that there was a clear need for further research.¹² Some of the new psychiatric units in general hospitals attempted to provide a comprehensive service to their catchment areas but others treated a limited number of patients who had been selected because of their good prognosis and for the ease of their management in medical wards.¹²

As the decades passed, newer psychiatric facilities in general hospitals avoided some of the design flaws of their predecessors. There was an increasing emphasis on specially designed buildings that were situated on general hospital sites but separate from the main buildings. In 1994 the House of Commons Health Committee reviewed the effectiveness of the United Kingdom's mental health services.¹⁸ The Committee believed that an acceptable mental health service should provide functions like those of the old institutions, together with some additional functions, but that a new service might do so in a different location and in a different manner. The Committee identified fifteen significant and desirable functions of the old psychiatric institutions. Some of these functions (food, clothing, basic income) had now become the responsibility of social security services, while others (assessment and treatment, outpatient care) had mostly been transferred to the district general hospitals. Long-term care for the developmentally delayed and for the management of forensic cases had been absorbed by specialized services, although the latter were very inadequate. Other functions of the old mental hospitals such as respite care, asylum, shelter, recreation, 'a social world', and

occupational rehabilitation, while notionally the responsibility of local social services, had ceased to exist in many parts of Britain. In the Committee's view, the mental hospitals had achieved real economies of scale, but this gain was offset by a lack of independence of choice, of privacy, and of individualised care for patients.¹⁸

In 1995 Freeman criticised the Hospital Plan because it lacked details about costings and because it recommended community care without full details regarding the funding and organisation of that care.² Freeman concluded that general hospital psychiatry had a limited meaning if viewed in isolation, not least because serious psychiatric disorders have a strong tendency to recurrence and to chronicity.² For example, psychiatrists universally recognised that the treatment of severe depression should not conclude in weeks or months but should extend for several years. Within those years, the patient might only spend a short time as an inpatient, but the episode of inpatient management had to be integrated with outpatient care, and day-hospital attendance. In some cases it might also be necessary to check on, and to supervise patients in their homes. Following the resolution of all psychiatric symptoms the patient would still require long-term oversight by a general practitioner. Freeman was anxious about the management of severe and long-term mental illnesses in general hospitals: 'Perhaps general hospital psychiatry has always contained an inherent flaw, in that it was designed essentially for the management of acute illness.'²

A survey of inner-London psychiatric units published in 1994 by the Royal College of Psychiatrists revealed that those units were running at an average capacity of 111 percent.¹⁹ It suggested, too, that if patients who suffered from severe depression were able to gain admission to one of those overcrowded wards, they would find themselves in an environment that was far from suitable for the treatment of their condition. The managers of the psychiatric

wards in the district general hospitals were attempting, often unsuccessfully, to deal with formidable challenges. Those wards were accumulating patients who had chronic disabilities and chronic mental disturbances. It was clinically wrong, unethical and dangerous to discharge those patients and it was nearly impossible to place them in appropriately staffed hostels or in facilities that were able to provide adequate security. Therefore, those clinicians and managers were unable to free up beds for new admissions. In these circumstances, few new patients would gain admission unless their behaviour posed a danger to themselves or to others.

1.7 Consultation and liaison psychiatric services in the United Kingdom

There are limited data concerning the extent of psychiatric consultation on medical and surgical wards in Britain during the first half of the twentieth century. It is nevertheless well documented that British psychiatrists were sometimes asked, in general hospitals, to assess cases of attempted suicide and that after 1945 those consultations became more frequent.¹ The Mental Health Act of 1959 mandated that cases of attempted suicide be assessed by a psychiatric service before their discharge from a general hospital. Consultation for attempted suicide then became a focus of research by several British academic psychiatrists including Erwin Stengel (Edinburgh and then Sheffield) and Keith Hawton (Oxford). Psychiatric consultation services became established in the medical and surgical wards of several major hospitals in London: University College (Max Hamilton), Guy's (David Stafford-Clark), the Middlesex (Denis Hill) and at Dulwich (Michael Shepherd). At the Middlesex Hospital, Denis Hill and his colleagues organised a system of liaison psychiatry modelled on that at Rochester, New York, where Romano and Engel had created liaison attachments to individual medical units. However, in the United Kingdom the development of liaison psychiatric services to medical, surgical and obstetric units was much slower than in the US

and many hospitals had to rely either on informal or duty psychiatrists to perform psychiatric consultations.^{20,21} In 1983, a Psychiatrists' Liaison Group was created within the Royal College of Psychiatrists but by 1985 there were still few full-time liaison psychiatrists in general hospitals.²¹ As late as 2007 it was reported that the overall practice of consultation-liaison psychiatry in the United Kingdom remained haphazard.³

1.8 Accounts of the history of general hospital psychiatry in the United States

There are many well researched and authoritative accounts of the history of general hospital psychiatry in the USA.²²⁻³² These accounts often place emphasis on different aspects of psychiatry as it migrated from the mental asylums into the general hospitals and eventually started to move into the communities that surrounded those general hospitals. During the first decades of the twentieth century, publications from North America proposed that, in order to manage early and incipient cases of insanity, 'neuropathic' or 'psychopathic' wards should be created in general hospitals.³³⁻³⁷ Between the 1930s and the 1950s there was a steady stream of journal articles and books about the place of psychiatry in general hospitals, and that flow accelerated after 1960.³⁸⁻⁴⁰ During the 1960s and 1970s several periodic journals appeared in the USA which focussed on psychiatry in the general hospital. They included the *Journal of Hospital and Community Psychiatry*, which was launched by the American Psychiatric Association in 1966. The name of that journal was changed to *Psychiatric Services* in 1994. In 1979 the publishing company Elsevier launched the journal *General Hospital Psychiatry* which was intended to focus on linkages between psychiatry, medicine, and primary care and which espoused a biopsychosocial philosophy. Several books appeared in the 1960s with the phrase 'general hospital psychiatry' in their titles. The compendium *Frontiers of General Hospital Psychiatry* appeared in 1961 but was not followed by subsequent editions.⁴¹ *The Massachusetts General Hospital Handbook of General Hospital Psychiatry* appeared in

1978.⁴² It was followed by seven new editions and has achieved international status as a standard textbook for liaison psychiatrists.⁴³ Since 2000 there have been fewer books or journal articles published with titles that include the phrase ‘general hospital psychiatry.’ This might be because there is no continuing need to differentiate psychiatry that is practiced in general hospitals from psychiatry practiced outside those general hospitals or because psychiatry in general hospitals has split into two separate sub-disciplines—consultation-liaison psychiatry and community-oriented psychiatry or ‘integrated psychiatry’— so that the phrase ‘general hospital psychiatry’ is becoming obsolescent.

1.9 The management of mental illness in the United States in the nineteenth century

During the nineteenth century, the development of psychiatric services by the creation and the maintenance of lunatic asylums followed similar trajectories in the USA and in the UK. Between 1830 and 1890, the management of serious mental illness became the bailiwick of the mental hospitals. From 1830 general hospitals, which had participated in a limited fashion in the management of lunacy, withdrew almost entirely from the treatment of severe mental illness.⁴⁴

It would be a mistake to think that, between 1830 and 1890, the general hospitals in the USA, or those in other industrially advanced nations, enjoyed the degree of public trust and admiration they would accrue by the middle of the twentieth century. General hospitals might be less feared and disparaged than mental hospitals but they were mostly regarded with disdain and apprehension. Conditions within medical and surgical wards were usually grim and insanitary and most citizens feared that admission to those wards would not lead to recovery; indeed, it was widely thought that if one was ill, it would be safer to seek therapeutic attention elsewhere. General hospitals and their policies were not always under

the supervision of medical practitioners; the clinical staff who attended patients typically had limited specialised training or skills. However, during the last quarter of the nineteenth century those same hospitals underwent a remarkable transformation.^{45,46} The number of general hospitals increased, and the quality of their clinical services improved. The reasons for those advances are complex; they included changes in the theory and practice of medicine, changes in the administrative structure of hospital services and a general increase in public respect for science. Another factor in their advancement was the profit motive.^{45,46} As general hospitals attracted fee-paying private patients, they became financial ventures which proved increasingly appealing to investors. Between 1880 and 1925, the percentage of paying patients in hospitals in New York State rose from around 28 percent to 80 percent and their contribution to hospital income rose from about 10 percent to 40 percent.^{29,47} As general hospitals became more prosperous and gained increasing public respect, they became more attractive to medical practitioners who would then vie for professional appointments. Among those medical practitioners were specialists in neurology and in psychiatry.⁴⁶ Those neurologists and psychiatrists sometimes competed for the fees of patients. Some neurologists were justifiably critical of alienists and mental hospitals but the motives of other neurologists who criticised psychiatric consultancy and care were likely less noble.⁴⁶ Some psychiatrists banded with neurologists to criticise the practices of alienists and the standards of care in the mental asylums. However, when it came to the care and treatment of persons who had severe mental illness—many of whom were uncooperative and disruptive—neurologists, general hospital psychiatrists and general hospitals themselves had very little to offer. These specialists, and the general hospitals, therefore learned to avoid competing with the asylums for the custom of manifestly insane persons.^{45,46}

Yet the story was different when it came to the management of patients who had non-psychotic mental disorders, and who were cooperative with hospital procedures. In 1879 a psychiatric pavilion was established at the Bellevue Hospital in New York and several other general hospitals followed suit. In 1902, a psychiatric pavilion was created in Albany, NY, under the direction of Dr J Montgomery Mosher, that came to be regarded as a milestone in the history of general hospital psychiatry.⁴⁸⁻⁵⁰ Mosher regarded general hospital psychiatry as supplementing rather than replacing psychiatric treatment in the homes of patients, treatment in private hospitals, or custodial care in psychiatric hospitals.⁴⁹ Despite the great international interest aroused by the clinical experiment at Albany, only a small number of American hospitals created psychiatric annexes or wards prior to the 1930s and the advent to Dr Alan Gregg.⁵⁰

Gregg joined the Rockefeller Foundation in 1922 and became the Director of its new Medical Sciences Division in 1931. Gregg had been influenced by James Jackson Putnam, Chief of Neurology at Massachusetts General Hospital. Putnam had spent time with Freud in 1909 during the latter's visit to the USA and was a forceful proponent of psychoanalytic ideas.⁵⁰ Gregg was also motivated by the conviction that severe psychiatric illnesses should be examined by the techniques of modern medicine. This would demystify them and remove them from the realm of moral culpability, much as had been done for other medical conditions.⁵⁰ Gregg wished to foster the establishment of psychiatry as a medical specialty. He also encouraged the introduction of psychiatry into the general hospitals because he was convinced that psychiatry had the potential to contribute to medical care and education.⁵⁰ Gregg used his position within the Rockefeller Foundation to channel a significant proportion of its largesse towards research, education and clinical services that related to mental health. Beneficiaries included the Massachusetts General Hospital, Barnes Hospital (Missouri), Duke

Hospital (North Carolina), Billings Hospital (Chicago) and the Montreal Neurologic Institute, where Wilder Penfield was investigating the psychiatric aspects of temporal lobe function. In London, the Rockefeller Foundation assisted the Hospital for Nervous Diseases at Queen Square and the Maudsley Hospital.⁵⁰ In Sydney the Foundation supported the construction of the New Medical School at the University of Sydney, but that assistance was not directly related to psychiatry. All told, the Foundation spent nearly eleven million dollars on these bequests between 1931 and 1941—in those years an enormous sum of money. Gregg's enthusiasm for GHP drew the attention of governments and other organisations to the importance of psychiatry in general hospitals and stimulated them to add their support.⁵⁰

Between 1930 and the early 1940s the number of general hospital psychiatric units in the US increased from eight to forty.⁵¹ During this early phase in the development of GHP in the United States it became evident that the mental health professionals who migrated into general hospitals were motivated by two ideologies. Those health professionals worked closely together to secure a base in those hospitals but would, in the 1970s and 1980s differentiate in pursuit of separate goals. The American psychiatrist-historians of GHP, Summergrad and Hackett, labelled the authors who commented on developments in general hospital psychiatry in the 1970s and 1980s as belonging to two groupings—a 'Social/Reformist Group' and a 'Medical Group'. The Social/Reformist Group shared the widespread conviction, in the 1970s and 1980s, that the general hospitals were sanctioned places for the provision of scientific and compassionate therapy and were well placed to offer effective treatments for all types of mental and physical illness. The general hospitals were also the appropriate place for psychiatry because patients could be treated in a more open manner, away from the custodial care provided by the old mental hospitals. Many Social/Reformists who were active in the 1960s and 1970s, regarded the chronicity of mental

illnesses as more a reflection of factors in the person's institutional experience than a consequence of brain disease. The Social/Reformists generally adhered to the biopsychosocial model of illness devised by Romano and Engel in Rochester, NY. They believed that the presence of mental health professionals in the wards and clinics of general hospitals had the potential to transform medical education and practice and would make health professionals more humane and more patient oriented. The second group of mental health professionals who espoused GHP were the 'Medical Group'. This group felt that links with medicine were central to the identity and growth of GHP. They wished that psychiatry would become a respected specialty area within medicine and that psychiatry would achieve a place close to the heart of medicine. For the 'Medical Group', the skilled use of psychopharmacology and the engagement of psychiatrists with medically ill patients were major aspirations. The Medical Group assigned great priority to neurobiological research.⁵¹

Other factors that aided the rise of GHP in the USA during the first half of the twentieth century included the influence of Adolf Meyer and of his 'common sense' school of psychiatry; new ideas derived from psychoanalysis and from studies of psychophysiology; the experiences of psychiatrists who managed psychiatric disorders that resulted from combat and trauma during the two world wars and, in 1949, the establishment of the National Institute of Mental Health.³¹ It will be shown in *Chapter Nine: The impact of new treatments on psychiatric services*, that the migration of mental health services into general hospitals during the late 1950s and the 1960s and the later extension of psychiatric services into nearby communities, only became feasible because of the advent of radically new biological treatments including antipsychotic and antidepressant drugs. That migration was encouraged by increasingly strident media criticism of mental hospitals and of their poor standards of care. The late 1960s and the 1970s also saw the rise of a community mental health movement

that was determined to prevent the ‘institutionalisation’ of psychiatric patients which stemmed from their incarceration for long periods in mental hospitals.^{53,54} By 1998 there were more than 54,200 psychiatric beds in general hospitals in the USA.⁵⁴ Whereas those beds constituted only about twenty percent of all the psychiatric beds in the USA, general hospitals were managing more than double the number of episodes of psychiatric care than were managed in the mental hospitals.⁵⁴

With the appointment of numerous mental health professionals to the staff of the general hospitals it became possible to introduce a wide variety of psychiatric services and programs, including psychiatric outpatient clinics, consultation-liaison services, emergency psychiatric services, partial day and night psychiatric programs, children’s psychiatric services, psychopharmacology clinics, walk-in clinics, behavioural medicine programs, substance abuse programs, geropsychiatric care programs, and other specialised programs.⁵⁵ The mental health professionals who belonged to the Medical Group rejoiced in these consequences of the migration of psychiatry into the general hospitals and saw great merit in the strengthening of the links between psychiatry and general medicine. A prominent member of the Medical Group, Bish Lipowski, articulated a view commonly held by members of that group when, in 1981, he wrote:

The remarkable growth of general hospital psychiatry in the last 50 years, and especially in the last 20, represents one of the most far-reaching developments in psychiatry’s history. More than any other organisational change, that development has helped to raise the standards of psychiatric patient care, training and research and to reduce the isolation of psychiatry from progress in the rest of medicine.⁵⁵

However, it should never be thought that the metamorphosis from asylum psychiatry to general hospital psychiatry in the USA proceeded without complications or casualties. Many experts have expressed misgivings about the quality of psychiatric care that has been available to the seriously mentally ill citizens of the USA since the 1960s, and especially since 1980.^{54,57} Great concern has also been voiced about the costs of psychiatric services that have been borne by individual patients, by their families and by the nation as a whole. Donald Lipsitt has argued that the introduction of the philosophy and the practice of managed care during the 1980s seriously damaged the quality of care available to the mentally ill in the USA.⁵⁴ Managed care was explicitly designed to cut the costs of health services. One of the ways it achieved this was by reducing the duration of psychiatric admissions from about 30 days in the 1980s to about 6 days in the late 1990s. Managed care introduced rigorous guidelines, restrictions, regulations and reimbursement schedules on patients, physicians and hospitals. The options available to psychiatrists and to hospitals in the way that they were able to accommodate, care for and to treat mental disorders were severely compromised by the imposition of managed care.⁵⁴

One of the aims of the mental health professionals who introduced psychiatry into the general hospitals during the 1960s and 1970s was to bring psychiatric services closer to the communities that psychiatry was intended to serve. During the 1980s, the sociologist Leona Bachrach published several important papers about the problems facing community-oriented psychiatry in the USA.⁵⁸⁻⁶⁰ Bachrach elucidated certain unwanted consequences, for seriously mentally ill persons, of the closure of beds in state mental hospitals. She worried that chronically and recurrently mentally ill persons, and a new cohort of mentally disturbed young persons, were increasingly dependent on services provided by the inpatient, outpatient and emergency departments of the general hospitals. She quoted evidence that chronic mental

illness was not diminishing among cohorts of young persons who had never been admitted to mental hospitals, and questioned the exact significance of 'institutionalisation'.⁶¹ Bachrach pointed out that general hospitals were not usually equipped to provide asylum, physical and emotional sustenance or long-term care and that a significant proportion of the general hospitals in the USA were funded by fee-paying patients or by the insurers of those patients. Private hospitals, argued Bachrach, have a strong tendency to reject responsibility for the management of disruptive, violent and involuntary patients. It was hardly surprising, then, that compared with private hospitals, publicly funded hospitals had a larger proportion of patients categorised as schizophrenic and a smaller proportion who were categorised as depressives.⁶² Bachrach warned psychiatrists, and her other readers, that competition between these providers, and their failure to coordinate effectively, was bound to leave some seriously mentally ill patients poorly attended, with serious negative consequences.⁵⁸⁻⁶²

In 1985, a paper by Canadian psychiatrists Alex Richman and Pamela Harris argued that North American general hospitals were providing two distinct types of psychiatric service to the communities in which they were embedded.⁶³ They labelled these two modalities of service 'adjunctive' and 'pivotal'. Most of the general hospitals in the USA and in Canada that provided psychiatric services only offered an adjunctive service, which Richman and Harris characterised as follows: 'The adjunctive type of general hospital psychiatric division provides brief treatment to highly selective types of patients, and is relatively inaccessible to a wide variety of patients.'⁶⁴ In stark contrast to adjunctive psychiatric services, a pivotal modality of service offered the complete acceptance of responsibility for the management of all the psychiatric needs of a defined catchment area, broad admission criteria and effective discharge planning, staff reorientation towards community psychiatric needs, appropriate architectural features, and the ability to hear and to respond to the needs of the community.

General hospital psychiatric divisions that could offer pivotal functions would provide appropriate levels of inpatient care for the full spectrum of psychiatric disorders as well as linkages and backup services to extramural and community programs which were designed for the management of the long-term mentally ill. Pivotal services did not need the backup of mental hospitals for the management of involuntary patients or for patients who were usually rejected by adjunctive psychiatric services. Pivotal services were more likely than adjunctive services to collaborate with other agencies to develop programs for certain low prevalence disorders, as well as for alcoholism, for psychogeriatric patients and for adolescent disorders.⁶⁵

Richman and Harris quoted, with obvious respect, Bachrach's concerns about developments that challenged the viability of psychiatric services in the general hospitals, including Bachrach's speculation that the general hospital was being turned into 'a mini state hospital'. Richman and Harris noted that the pivotal model had been operating for many years in the United Kingdom, where about half the health districts had a general hospital psychiatric unit that gave a comprehensive service to all or part of that health district. They cited the sociologist Talcott Parsons' dictum that mental hospitals had previously met four essential needs of psychiatric patients: treatment, care, asylum and shelter. Richman and Harris opined that general hospitals in the USA and Canada had little difficulty in providing acute psychiatric treatment, but questioned whether they could, and should, attempt to meet the three other categories of need listed by Talcott Parsons. Richman and Harris made the important observation that '...when compared with Canada and the United States there seems to be less confusion in Britain regarding the intended role and functions of general hospital psychiatry.'⁶⁶ Richman and Harris concluded that decision-makers and planners were professionally obliged to make crucially important choices regarding the type of general

hospital psychiatric facility that they wished to incorporate within their mental health care systems—adjunctive or pivotal—and that, in 1985:

Currently, although both the mental hospital and the adjunctive general hospital psychiatric division can provide short-term psychiatric treatment, neither type of facility has attained the aim of providing care that is comprehensive, continuous, coordinated and community based. The pivotal general hospital division in its role as organiser and coordinator of services would be better able to realise these goals.⁶⁷

In 1991, when the academic historian Gerald Grob was concluding his account of the history of the transposition of American psychiatry from the mental hospitals to the geographic communities of the USA, he wrote:

... those who introduced new mental health policies during and after the 1940s firmly believed that the adoption of new mental health policies would lead to dramatic improvements...Although a broad constituency benefited from their innovative policies, many who required the most assistance—especially the chronically mentally ill—lost. More than a century and a half after a system of public mental hospitals was created, Americans had yet to define a mental health policy that integrated decent and humane *care* with access to medical services for severely and chronically mentally ill persons.⁶⁸

The contemporary American psychiatrist-historian of general hospital psychiatry, Donald Lipsitt, insists that, following the introduction of managed care policies in the 1980s there has been a decline in the quality of the clinical management of many mentally ill persons in the USA. He particularly deplores the increasing costs of care for individual patients, and for their families, and increasing interference in the therapeutic decision-making of mental health

professionals⁵⁴ Grob and Lipsitt belong to a respected company of psychiatrist-historians and academic historians who share the view that, during the twentieth century, *therapies* provided to the seriously mentally ill have significantly improved but that the *care* of the seriously mentally ill in the USA has not always advanced and that it certainly has, in many instances, declined.

1.10 Conclusions

For most of the nineteenth century, the evolution of psychiatric services in the UK and in the USA followed similar trajectories. In both countries the management of cases of serious mental illness necessitated the certification and admission of insane persons into lunatic asylums. The general hospitals avoided engagement in the management of overt insanity until the 1890s when some psychiatrists in both countries proposed that cases of incipient mental disorder should be voluntarily admitted into general hospitals to encourage prompter assessment and treatment. General hospitals in the USA were quicker to implement this policy than those in the UK. In part this was because the profit motive was more compelling in encouraging the admission of cases of incipient mental disorders into general hospitals in the USA than in the UK. The characteristics of psychiatric services in the USA and the UK diverged further in the 1930s, because mental health professionals in the USA were more ready than those in the UK to entertain psychoanalytic ideas and because Alan Gregg, at the Rockefeller Foundation, fostered the entry of psychiatry into American general hospitals. In 1949 the creation of the National Institute of Mental Health also contributed to the growth of general hospital psychiatry in the USA. Across the Atlantic, in 1946, the British National Health Services Act would exaggerate the existing differences in the trajectories of psychiatric services in the USA and the UK.

Thousands of kilometres from the UK and the USA, it was predictable that many of the social, legal, medical, and psychiatric practices which had evolved during several centuries in the United Kingdom would be adopted and modified in the British Colony of New South Wales. However, the shape of psychiatric services in the new antipodean society would be influenced by many additional factors. These would include the great distances between seaports and centres of population, the influence of new ideas which had their origins in the United States of America and the migration of peoples from many nations. The exact outcome of those fashioning processes on the general health services and on the psychiatric services of New South Wales would become apparent in the second half of the twentieth century.

Chapter Two will examine the small literature concerning the evolution of general hospital psychiatry in the colonies, states and territories of Australia. The remaining eleven chapters of this dissertation will then proceed to compare the evolution of psychiatric services in New South Wales with the evolution of general hospital psychiatric services in the UK and in the USA.

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Chapter Two

The evolution of general hospital psychiatry in New South Wales and other parts of Australia

2.1 Introduction

Chapter Two examines the published literature concerning the evolution of psychiatric services in New South Wales and other parts of Australia. The chapter then focusses on the literature concerning the entry of psychiatry into the general hospitals of the State of New South Wales (NSW). In the 1960s and 1970s, after a massive migration of mental health professionals into the general hospitals of NSW they subdivided into a community-oriented group and a consultation-liaison group. Therefore, this chapter includes reviews of the literatures concerning the evolution of community psychiatric services and concerning the evolution of consultation-liaison psychiatric services in NSW. The chapter comments briefly on the development of psychiatric services outside the boundaries of New South Wales, especially in the State of Victoria, but only to the degree that those developments had a direct impact on developments in psychiatric services in New South Wales.

2.2 Published accounts of the history of psychiatric services in New South Wales

All published narratives about psychiatric services in Australia take their starting point as the shores of Sydney Cove in January 1788. In that year, the borders of New South Wales encompassed an enormous jurisdiction that extended thousands of kilometres to the west, to the south and to the north of Sydney Cove. In 1825, when Tasmania became a separate colony, New South Wales became defined as a jurisdiction that could be more readily governed from Sydney. This was followed in 1851 and 1859, respectively, by the delineation

of the Colonies of Victoria and Queensland. While the geographic scope of the present study is limited to the State of NSW, there have been developments in psychiatric services in other parts of Australia that have been relevant to the development of psychiatric services in NSW and which must therefore receive some attention in this dissertation. However, the dissertation does not attempt to describe the development of psychiatric services outside the boundaries of New South Wales.

The first historians of psychiatric services in Australia were medical graduates, mostly psychiatrists, the best known of whom were John Bostock and Eric Cunningham Dax. These early histories commence with accounts of the efforts of the Governors of New South Wales to control and to manage acts of lunacy by placing ‘lunatics’ and ‘ideots’ in gaols or, after 1811, in a system of mental asylums. The intention of these Governors was to maintain order, to limit social disruption, and to protect lives and properties within the young penal colony. At this earliest stage of the creation of mental health services, the main theme of historical accounts of psychiatric services was the *control* of the mentally ill. During the first decades of the colony of New South Wales, the role of the colonial surgeons in the management of madness was limited to the confirmation of a diagnosis of insanity and the provision of professional advice about medical therapeutics. The theme of *care* was hardly evident until 1814, when Lachlan Macquarie instructed his appointee as manager of the Castle Hill Lunatic Asylum, Mr George Suttor, that the inmates of the asylum were to be managed with ‘mildness, kindness and humanity.’¹

Tensions between themes of *control*, *care* and *therapy* were played out in the mental asylums of NSW for the next one hundred and seventy years. There is good evidence that, especially between 1900 and 1950, the NSW Government was more concerned about *control* than about

care or therapy. The Annual Reports of the Inspectors-General of the Insane, contemporaneous government inquiries and royal commissions, and reports in newspapers and journals, all provide evidence that, after 1900, the NSW Government failed to construct and to maintain enough accommodation for the mentally ill to allow even the most basic of living standards for their inpatients. Overcrowding and dismal conditions in the asylums made it impossible to perform the principal modality of therapy, which was called ‘moral treatment’.

In their accounts of the history of psychiatry in NSW, these first psychiatrist-historians reported that, between 1898 and 1935, the Inspectors-General of the Insane consistently struggled against the parsimony or the indifference of governments towards the mentally ill, and that the intentions of most of the senior alienists were admirable in the face of circumstances that were not conducive to care and to therapy. The same authors report that the achievements of several psychiatrist-administrators—especially those of Norton Manning (1868-1898) and Eric Sinclair (1898-1925)—were significant examples of leadership and of the *mastery* of adversity.

In 1951, the psychiatrist, John Bostock published his account of the history of psychiatry in the Colony between 1788 and 1848.¹ Bostock’s book, titled *The Dawn of Australian Psychiatry* described the management of cases of insanity before and after the creation of the Tarban Creek Lunatic Asylum in 1838. Bostock was often critical of the quality of the care given to the mentally ill. Instead, Bostock emphasized the *mastery* of adversity and mental illness by certain physicians and nonphysicians as they jostled for control of the management of the Tarban Creek Asylum. One chapter in *The Dawn of Australian Psychiatry* reproduces case notes penned by Dr Francis Campbell at Tarban Creek Asylum, between 1848 and 1850.

Bostock regards these notes as constituting a ‘clinical masterpiece.’² In a lecture that he delivered in 1949, titled *A Psychiatric Centenary*, Bostock reviewed developments in psychiatry between 1848 and 1948.³ Neither his book nor this lecture included any details about the role of general hospitals in the management of mental disorders.

In 1968, the retired senior Victorian psychiatrist, CRD Brothers published an account of the development of psychiatric services in the State of Victoria. Brothers’ text contains several pages concerning the creation of psychiatric wards in five country towns of Victoria in the late nineteenth century.⁴ The relevant data from those pages are important and will be revisited in *Chapter Five* of this dissertation. In several publications, Professor WS Dawson provided brief accounts of the growth of psychiatric services in NSW during the 1950s and 1960s but had little to say about the role of general hospitals in the psychiatric service of NSW.^{5,6} Dawson’s career and his writings will be returned to in *Chapter Eight: Psychiatry in the doldrums (1925 to 1961)*. Eric Cunningham Dax authored a book on the development of the Mental Health Authority of Victoria and a chapter on the history of psychiatry in Australia and New Zealand in *Howell’s World History of Psychiatry (1975)*. Dax also authored a paper concerning the history of Australian psychiatry in the *American Journal of Psychiatry*, three papers in the *Australian and New Zealand Journal of Psychiatry* and one in *Australasian Psychiatry*.⁷⁻¹³ These accounts focus, largely, on the development of psychiatric services in the State of Victoria. Dax was the Chairman of the Victorian Mental Health Authority between 1951 and 1968 and, in this role, was intent on bringing psychiatry to the Victorian community with minimal engagement of the general hospitals as a conduit for that transposition. His attitudes concerning GHP are clearly stated in his book, *Asylum to Community (1961)* and will be discussed in *Chapter Ten* of this dissertation.¹⁴ Ken Kirkby’s

paper, titled ‘History of Psychiatry in Australia: Pre-1960’, provides a brief and broad perspective of the history of psychiatry in Australia but gives no details concerning GHP.¹⁵

The contributions of the academic historians Catharine Coleborne and Dolly MacKinnon are mainly concerned with the implications and consequences of deinstitutionalisation, de-hospitalisation and community care—or the deficiencies in community care—on the lives of persons who have chronic or recurrent mental disorder or developmental disability.^{16,17} Of relevance to the current research project, MacKinnon and Coleborne record the citation of an editorial piece in the *MJA* as follows: ‘...ever since the mental hospitals have placed patients in the community, there has been dispute as to whether the patients were gaining freedom and independence or whether they were simply being callously neglected’.¹⁸ Also of relevance to the current research project, MacKinnon and Coleborne observed that, unlike Britain and the USA, Australia and New Zealand have never relied heavily on private lunatic asylums or private psychiatric hospitals for the management of mental disorders. Their papers in 2003 and 2006 contain no details about general hospital psychiatry.^{16,17} Stephen Garton has written a great deal about the social history of psychiatry in Australia between 1880 and the present day.¹⁹⁻²³ However, he has never attended, in any detail, to the history of GHP. Milton Lewis’ book ‘*Managing Madness*’ has useful data about the administration of psychiatric services in Australia, including details relevant to the State of New South Wales but contains limited information about the entrance of psychiatry into Australian general hospitals.²⁴

The large monograph *A History of Medical Administration in New South Wales 1788-1973*, by Cyril Cummins is a valuable source of data about GHP in NSW.²⁵ Dr Cummins was the Director-General of Public Health for NSW between 1959 and 1975 and had a commanding role in the transformation of psychiatric services in NSW during those sixteen years. Many

important data about general hospital psychiatry are scattered throughout the length of Cummins' monograph. Cummins stressed the importance of the fact that, in NSW, medical and hospital services were born and developed separately from mental health services. According to Cummins they remained distinct from each other as theoretical, legal, administrative and material entities until the 1960s.

2.3 Published accounts of the developmental history of psychiatric services in the general hospitals of New South Wales

No comprehensive account of the entry of psychiatry into the general hospitals of any of the states or the territories of Australia has yet been published. Nonetheless, some papers detailing the entry of psychiatry into certain general hospitals in NSW and in Victoria have appeared in various professional journals. Perhaps the earliest journal article concerning psychiatric practice in an Australian general hospital is the one penned in 1902 by the Victorian physician, John Springthorpe.²⁶ Springthorpe's paper includes accounts of his management of three patients at Melbourne Hospital. That paper is discussed in *Chapter Six: new proposals for a new century*. After Springthorpe's paper, a half century elapsed before more articles concerning the entry of psychiatry into Australian general hospitals appeared in a peer-reviewed journal. In the 1960s, three papers that had some relevance to general hospital psychiatry appeared in the *Medical Journal of Australia*. These papers were: Gold's 'A Study of In-patients with Psychiatric Problems in a Tasmanian General Hospital' and Mai's 'General Hospital Psychiatry: Data Analysis of a Unit and Woodforde's A General Hospital Psychiatric Unit'.^{27,29} Of these, only Woodforde's text has any great relevance to the current research project. Woodforde's paper describes, in considerable detail, the functioning of one of the first general hospital psychiatric units in Sydney.²⁹ The contents and the implications of that paper are discussed in *Chapter Ten: A renaissance in psychiatry in New*

South Wales (1961-1994). A decade after Woodforde's paper, Associate Professor Peter Burvill published an article with the title 'Psychiatric Units in General Hospitals' which compared the differences between the objectives and the functioning of general hospital psychiatric units in England and Wales with those of the psychiatric units that were intended for Australia.³⁰ Burvill's paper proved to be very relevant to the present research project and is discussed, alongside Woodforde's paper, in *Chapter Ten: A renaissance in psychiatry in New South Wales (1961 to 1994)*.

In 1991, a book edited by two Australian psychiatrists and an American psychiatrist was published under the title *Handbook of Studies on General Hospital Psychiatry*. Despite its title, this book contained no specific data concerning the entry of psychiatry into Australian general hospitals.³¹ During the same decade the term 'general hospital psychiatry' seemed to be losing its former currency. This might have been because, by 1990, most of the mental health professionals who provided acute psychiatric services in NSW had moved out of the mental hospitals and the term 'general hospital psychiatry' as a point of distinction from 'mental hospital psychiatry' had lost most of its utility. When, in the first year of this research project, I performed precursory searches for titles that might be relevant to general hospital psychiatry, I noticed that the number of annual publications concerning 'general hospital psychiatry' plateaued in the 1980s. This suggested that the term 'general hospital psychiatry' was becoming obsolescent. Details concerning these searches are included in *Appendix One: Methodology*. During the 1980s and the 1990s the frequency of publications concerning 'community psychiatry' steadily increased and the frequency of publications concerning 'liaison psychiatry' escalated exponentially.

2.4 The literature concerning the development of consultation-liaison psychiatry and community psychiatry in Australia

A small literature concerning the collaboration of Australian psychiatrists and psychiatric nurses with physicians, surgeons and anaesthetists began to appear in the 1960s.³²⁻³⁵ There are few articles in Australian peer-reviewed journals that have the terms ‘consultation-liaison’ or ‘liaison psychiatry’ in their title, or which can be identified by database searches that employ the keywords ‘liaison psychiatry’ and ‘Australia’ or ‘New South Wales.’ By far the most relevant paper concerning the history of Consultation-Liaison Psychiatry (hereafter, C-LP) in Australia is that of Smith, Clarke and Herrman.³⁶ That paper, published in 1993, describes the evolution of C-LP in Victoria, highlighting once more the lack of similar accounts on the evolution of C-LP in NSW or other states. Very recently, Robert Gribble published a chapter containing a brief account of the evolution of C-LP in Australia in Hoyle Leigh’s *Global Psychosomatic Medicine and Consultation-Liaison Psychiatry*.³⁷ Data from all the sources listed in this paragraph are discussed in this dissertation in *Chapter Twelve: The birth and growth of consultation-liaison psychiatry in New South Wales*.

Community psychiatric services in New South Wales had their inception in the 1960s. During that decade, Dax and Barclay published two of the earliest Australian accounts of preventive psychiatry and community psychiatry.^{7,38} Both authors discussed theoretical issues and organizational goals but offered few details about the physical and staffing realities of community mental health services in NSW.^{7,38} While the goal of this dissertation is not to assemble a comprehensive account of the evolution of community psychiatric services in New South Wales, I nonetheless provide some level of overview in *Chapter Ten: A renaissance in psychiatry in New South Wales (1961 to 1994)* in which there are some details concerning the development of community psychiatric services affiliated with the Royal

Prince Alfred Hospital. Readers who wish to know more about the history of community psychiatry in Australia might refer to brief accounts found in Rosen A. (2006) and in Rosen A, Gurr R and Weir W. (2012)^{39,40}

2.5 Conclusions

This chapter draws attention to the great disparity between the historiography of general hospital psychiatry in New South Wales, and the other states and territories of Australia, when compared with the historiography of general hospital psychiatry in the United Kingdom and the United States. That disparity is particularly evident when it is demonstrated that no comprehensive account has yet been published concerning the evolution of GHP in any of the states or territories of Australia.

Following a review of the literature concerning the evolution of GHP in Australia, I concluded that a skeletal basis for the creation of an account of the evolution of GHP in NSW could be assembled from the Annual Reports of the Inspectors-General of the Insane for NSW and from the Annual Reports of the Directors of the State Psychiatric Service who succeeded them after 1958. That skeleton could be fleshed out by data from many sources, including from reports derived from official inquiries and royal commissions, from archival material, from articles that have appeared in professional journals, and from contemporaneous reports in the local media. By utilising many sources I saw it feasible to create a narrative account of the history of general hospital psychiatry in NSW. It would then be possible to comment on the ways in which the evolution of GHP in NSW was linked to, was similar to, or differed from the evolution of general hospital psychiatry in the United Kingdom and in the United States of America.

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Chapter Three

An overview of the development of medical and hospital services in New South Wales (1788 to 1961)

3.1 Introduction

It is an important fact that the hospital and medical services of NSW evolved separately from the psychiatric services and that those services remained apart until the 1960s. This chapter provides a brief overview of the evolution of medical and hospital services in New South Wales (NSW) between 1788 and 1961. The evolution of the mental health services of New South Wales between 1868 and 1994 will be described in *Chapters Five, Seven and Eight*. The amalgamation of non-psychiatric and psychiatric services in NSW will be described in *Chapter Ten: A renaissance in psychiatry in New South Wales (1961 to 1994)*.

3.2 The adoption of British medical and hospital practices in the Colony of New South Wales

The main part of the First Fleet of eleven ships left Portsmouth on the 13th of May 1787 to establish a penal colony in New South Wales. On board were close to 1,500 persons. Half were convicts; the others were marines, seamen, civil officers and a small number of free men and women. The Fleet carried nine naval surgeons, four of whom were already designated to form the Colonial Medical Service of NSW. Those four surgeons, and their successors, conveyed to New South Wales the essence of medical practices that had developed in Britain over the course of several centuries. Thereafter, for more than a hundred and fifty years, Australia would continue to derive much of its theory and practice of medicine—and of psychiatry—from Britain. On January 26th, 1788, within twenty-four hours

of the disembarkation of the colonists at Port Jackson, Surgeons White and Balmain were setting up hospital tents to accommodate more than sixty patients on the western shore of the small bay that had just been named Sydney Cove. There were four patients to a tent and they lay on straw, with only one blanket between them. A group of convicts was selected to act as attendants and nurses. This was the Sydney tent hospital. It was notionally the equivalent of a British naval hospital but extraordinarily crude and flimsy in its materials.^{1,2}

In July 1790, after a disastrous voyage that wasted the lives of nearly two hundred and fifty convicts and damaged the health of many others, the Second Fleet arrived in Port Jackson. Scores of additional tents were erected for the overflow of newly arrived patients. The Second Fleet also brought materials for the construction of a small portable hospital which would consist of two wooden buildings. Six years later the same buildings were re-erected northwards where they would be closer to Dawes Point. A fuller account of these events and of the earliest functioning of the Colonial Medical Service can be found in Cyril Cummins' *A History of Medical Administration in New South Wales 1788-1973*.¹

Although the Governors of New South Wales—Arthur Phillip (1788-1792), John Hunter (1795- 1800), Phillip Gidley King (1800-1806) and William Bligh (1806-1809)—had plenipotentiary authority, they had great difficulty managing the misbehaviour of the New South Wales Corps (1789-1810), which had arrived in Port Jackson with the Second Fleet.^{1,3} As a consequence there was much turbulence in the governance of New South Wales between 1790 and 1811. As Officers of the Crown, and as elite members of a small hierarchical society in New South Wales, the surgeons were individually and collectively involved in most of those disturbances.¹

Between 1788 and 1810 the official duty of the Colonial Medical Service was to provide hospital and personal medical services to all the members of the new colony, civil or military, including convicts and former convicts, to advise on matters of immigration, to deal with public health problems, to determine and assist in enforcing quarantine regulations, and to respond as best they could to outbreaks of infectious diseases, which presented a real threat to the isolated and fragile community at Sydney Cove. The colonists failed to pay great attention to the effects of those diseases on the aboriginal population. Within a short time, the surgeons also became engaged in the affairs of the Colony as magistrates, traders and businessmen. During the penal colony's first decades, the number of free persons—free settlers and freed convicts—steadily increased. By 1808 they and their children accounted for nearly a quarter of the Colony's population. The colonists relied as much on unqualified therapists, including druggists and 'quacks', for medical advice as they did on the surgeons of the Colonial Medical Service. The surgeons resented their lack of remuneration for their therapeutic attentions to free settlers and freed convicts and began a long-running dispute with the Governor over the right to charge for their professional services.¹ The eventual outcome of that confrontation was that they gained the right to charge fees to all non-victualled colonists who were not hospital inpatients—that is, those persons who the Government did not directly support with food and shelter. The surgeon's success in these negotiations was a small but vital step in a long and slow campaign by medical practitioners to create a viable and independent medical profession in New South Wales.

The New South Wales Corps, which became known as the Rum Corps, steadily acquired much de facto power and its members quickly became engaged in the trading and business practices of the Colony. The surgeons, as officers of the Crown, were answerable to the Governor but they had to navigate the corrupting presence of the Corps. The Corps achieved

its greatest triumph and notoriety in 1809 when officers and soldiers marched on Government House and deposed Governor William Bligh. The officers escaped punishment for their unlawful rebellion, but the Corps was cast into disrepute and was recalled to Britain. Some of its former officers, including John Macarthur, remained in the Colony and continued to challenge the rule of the Governors. The dramatic removal of Governor William Bligh was followed by many months of poor governance, alleviated only by the arrival of a new governor, Lachlan Macquarie, and with him a turning point in the history of the administrative and social development of the Colony. Macquarie was determined to reverse the effects of the Rum Rebellion, and to bring honest, if autocratic order to the Colony. In this task he had the assistance of Judge Ellis Bent who had accompanied Macquarie on his voyage to Port Jackson.⁴

The Colony steadily and rapidly expanded. By 1811 the number of colonists exceeded 10,000. By 1817, the non-indigenous population of NSW exceeded 15,000 persons, of whom three quarters were either free settlers or emancipists – a term which applied to those who had served their sentences or been pardoned. As settlements extended beyond Sydney, hospitals of stone and brick were constructed, often adjacent to military barracks. Hospitals were commissioned at Parramatta, Liverpool, Windsor and Goulburn. During Macquarie's governorship (1810-1822) hospital and medical services extended to Bathurst and to Newcastle, but by far the main hospital was the one that Macquarie established in 1814 near Sydney Cove.^{1,2} One of Macquarie's earliest priorities was the construction of a new and better hospital for the Colony than the primitive facility near Dawes Point. When the British Government refused Macquarie's request for the funds to construct a new hospital, Macquarie adopted a radical plan, but one which was consistent with the commercial practices of the Colony. In return for the granting of a monopoly license to import spirits, two

entrepreneurial businessmen contracted to build a new hospital in the major street that was named after Macquarie. When it was completed in 1814, this building was locally known as 'The Rum Hospital'. Its construction was well below a desirable standard but better than the primitive structure at Dawes Point.^{1,2}

After transportation to New South Wales ceased in 1841 there was no need to maintain convict institutions. In 1842 the convict hospitals at Windsor, Bathurst and Goulburn were handed over to civilian control, followed by Port Macquarie, Newcastle and Parramatta Hospitals and finally, in 1848, Liverpool Hospital and the Infirmary at Sydney Hospital.⁵

3.3 The creation of voluntary hospitals in New South Wales

In 1816 the emancipist Dr William Redfern proposed that medical services should be provided for the indigent population of the Colony.⁶ In 1826 a group of prominent citizens led by Colonial Secretary Alexander McLeay appealed for public subscriptions to create the Sydney Dispensary. That appeal was successful, and a group of doctors volunteered their unpaid services to help paupers. The Sydney Dispensary quickly assumed great importance within the Colony. By 1838, it was providing medications for 1,300 new patients per annum.⁷ In 1845, when the board of the Dispensary endorsed the construction of inpatient wards in the south wing of the General Hospital, sometimes known as 'the Rum Hospital', and the facility was renamed the Sydney Dispensary and Infirmary.⁷ Like the voluntary hospitals that succeeded it, the Dispensary and Infirmary relied on public subscriptions and donations. The hospital underwent a tortuous saga of reconstructions. It had to be significantly rebuilt, and when it reopened in 1848 it was a substantial building with 150 beds and an operating theatre. That rebuilt hospital was nevertheless quickly beset by a raft of problems relating to drainage, sewage and vermin. It was destined for further major rebuilding.^{2,5,6}

In 1871, when the population of NSW was nearing 476,000, the Sydney Infirmary was the main general hospital in the Colony. It received 1,840 admissions during that year. St Vincent's Hospital, at nearby Darlinghurst, had 289 admissions, Parramatta had 76 and Windsor had 52. In 1871 the Sydney Dispensary serviced 5,972 outpatients, whereas St Vincent's serviced about 500 and Windsor 33.⁸ When St Vincent's Hospital had been created at Potts Point in 1857 by the Irish Sisters of Charity it became the second major voluntary hospital to be established in New South Wales. It was rebuilt in 1870 with 150 beds at its present site at Darlinghurst, a short distance from Darlinghurst Gaol.⁸ St Vincent's was initially supported by charitable donations and by the Catholic Church but during the first half of the twentieth century it would come to rely heavily—as did Sydney's other voluntary hospitals—on government funding.

In 1881 the Sydney Dispensary and Infirmary was renamed 'Sydney Hospital,' and a new round of major renovations began.² Those renovations lasted until 1894, by which time the Royal Prince Alfred Hospital—the first teaching hospital of the fledgling medical school of the University of Sydney—had been functioning for twelve years. The two institutions quickly began to compete for the position of the colony's most prestigious hospital. At that time St. Vincent's Hospital was also operating as a major voluntary hospital but, possibly because of its Roman Catholic origins and financial support, it remained outside that rivalry.

3.4 The status of the medical practitioners and the voluntary hospitals of NSW during the nineteenth century

In 1808 an examination board was created to list the professional qualifications of medical practitioners, but inclusion on the list did not guarantee the validity of qualifications or the

competence of practitioners.⁹ In 1838 a Medical Witness Bill was enacted to establish a public record of persons who could give medical evidence. The Bill thereby created a statutory authority—the New South Wales Medical Board—which would maintain that register. It took decades for the medical practitioners of NSW to organise themselves into a coherent and effective body, but, in 1880 the New South Wales Branch of the British Medical Association came into existence.⁹ The first issue of a professional medical journal in NSW—*The Australasian Medical Gazette*—appeared in 1881. Around that time the medical practitioners of New South Wales began to acquire the prestige which they craved. They were able to do so, in part, by linking their professional status to the ascendancy of science and by the increasing eminence of the Faculty of Medicine at the University of Sydney, which had been established in 1856. This prestige was aided by the continued strengthening of medical fiefdoms in general hospitals.

In 1881 there was a small but very alarming outbreak of smallpox in Sydney. The New South Wales Government quickly converted its small Advisory Board on public health matters into a Board of Health and ordered the construction of a temporary hospital at Little Bay sixteen kilometres to the south of Sydney Cove. This facility, which was initially called the Coast Hospital, immediately took the overflow of patients from the North Head Quarantine Station. It was always intended that the Coast Hospital would be available to deal with future outbreaks of infectious diseases and it did so following outbreaks of plague in 1900 and of influenza in 1919.¹⁰ The Coast Hospital expanded steadily, both in size and in its relative importance as a health facility within the healthcare landscape. At times when infectious diseases were less troublesome, the Coast Hospital took a significant proportion of the admissions of the impecunious population of Sydney who needed inpatient medical management.¹⁰ The Coast Hospital was destined to play an important role in the history of

infectious diseases and general health in NSW. In 1934 its name would be changed to the Prince Henry Hospital.

3.5 The administration of voluntary hospitals in New South Wales in the late nineteenth century

For the first three-quarters of the nineteenth century, and especially after the closure of the convict hospitals in the 1840s, the elected Government of NSW was not directly responsible for the maintenance and the management of the voluntary hospitals. Dr Cyril Cummins, who was supremely qualified as the Director-General of Health between 1959 and 1975 and who became a historian of medical administration in New South Wales, emphasized the autonomy which the general hospitals enjoyed in NSW during the late nineteenth and early twentieth centuries:

It cannot be stressed too frequently that general hospitals developed as voluntary charities for the indigent poor, and survived essentially on the subscriber system, with irregular Government assistance during the nineteenth century. Each hospital possessed its own executive authority in its hospital board and Government intrusion was minimal.¹¹

The board members of the general hospitals consisted of prominent local citizens and medical practitioners. The latter had considerable influence on the policies and on the administration of those hospitals. The status and income of medical practitioners in NSW were often linked to their hospital appointments. Therefore, the influence of the medical profession in New South Wales was closely aligned with the autonomy and power of the general hospitals.

The ability of the general hospitals to defy requests and instructions from the Government was illustrated in the 1880s by their refusal to assist in all matters related to insanity. In 1882 Frederic Norton Manning complained bitterly, in his Annual Report, that general hospitals in country areas had refused to assist his Department of Lunacy by allowing the accommodation of certified patients until they could be transferred to his mental hospitals in Sydney and Parramatta. This meant that, in country towns, mentally ill persons were detained in gaols until transportation to mental hospitals could be arranged.¹² This was a very unsatisfactory, regrettable and stigmatising way to manage mentally ill persons. This issue is discussed further in *Chapter Five: Lunacy services in NSW in the late nineteenth century*.

3.6 The NSW Government begins to gain control over the general hospitals

In 1913, when the New South Wales Government created a Ministry of Health, the responsibilities of a pre-existing advisory Board of Health were augmented and passed on to the newly created Department of Health. However, the Government still failed to gain effective control over the policies and the actions of the general hospitals. Well into the first half of the twentieth century, general hospital boards continued to focus more on what happened inside their wards than on the health needs of the communities which surrounded them. Their autonomy was, however, bound to diminish as the general hospitals admitted increasing numbers of patients who were not subscribers, and as the hospitals came to rely more heavily on government funding. The main channel for the admission to general hospitals of non-subscribing patients, or their nominees, was the Hospitals Admission Depot, which was situated towards the northern end of Macquarie Street. During 1916 over 12,000 persons were assessed at the Depot, of whom 3,420 were sent to the Coast Hospital, 436 to the Royal Prince Alfred Hospital, 267 to Sydney Hospital, 172 to the Women's Hospital in

Crown Street and 117 to the Hospital for the Dying. The remainder who required admission were sent to the State Asylums for the Infirm.¹¹

As admissions to general hospitals increased, and as health expenditure escalated, the Government became increasingly frustrated by its lack of control of the general hospitals. This frustration was forcefully expressed by the Inspector-General of Health, George Armstrong in 1923:

The question is a very important one for the State, as the method of control of Public Hospitals throughout NSW is rather haphazard. ... The Government which contributes practically half the cost of all hospitals retains very little effective control over these institutions, and hospital committees throughout the State have the power to do very much as they please. It is understood that a Bill is to be presented to Parliament at the forthcoming session.¹³

The Government passed its Public Hospitals Act in 1929. The Act created the Hospitals Commission of New South Wales, with the intention of supporting and coordinating the activities of the general hospitals. However, the Hospitals Commission had limited power to take command of the policies and the actions of the general hospitals. The extent of Government control would improve in 1973, when the Hospitals Commission was replaced by the Health Commission of New South Wales.¹⁴ The creation of the Health Commission of New South Wales and its relevance to the amalgamation of non-psychiatric and psychiatric health services will be discussed in *Chapter Ten: A renaissance in psychiatry: 1961 to 1994*.

3.7 Psychiatric outpatient clinics at general hospitals in New South Wales

In contrast to their opposition to the acceptance of any role in the management of psychiatric inpatients, in the 1920s the boards of the general hospitals cooperated in the establishment of psychiatric outpatient clinics. This would not have been difficult for the hospital boards; there was no significant need for security measures, for physical constructions and the cost of administering those clinics were minor. The clinics were staffed by unpaid honorary psychiatrists and by salaried medical officers from the mental hospitals. It seems that the first psychiatric outpatient's clinic in NSW was the one which was established in 1914 at St Vincent's Hospital. That clinic was small, and it only provided simple consultation and triage.¹⁵ In 1923 a large and important psychiatric outpatient's clinic was created at the Royal Prince Alfred Hospital (RPAH). It was led by the newly appointed Professor of Psychiatry at the University, and at RPAH, Sir John Macpherson. Eric Sinclair, the Director of the NSW Department of Lunacy, had a major role in the appointment of Sir John Macpherson and provided half of the ongoing funding for his Chair and for Macpherson's clinical services.¹⁶ The details concerning that 'special outpatient's clinic' will be discussed in *Chapter Seven: Under the leadership of Eric Sinclair, between 1898 and 1925, psychiatry enters the general hospitals of NSW*. Following the example at RPAH, psychiatric outpatient clinics were then established at most of the major general hospitals in New South Wales. Their creation would have required little government assistance other than instruction to the mental hospitals that their medical officers should provide some of the medical staffing required for the maintenance of those clinics.

3.8 The Federal Government enters the arena of health care by assisting ex-servicemen and their families

In the first years of the Second World War there was a major development in medical and psychiatric services in New South Wales. In 1941 the Federal Government rebuilt the 113th

Military Hospital in the Sydney suburb of Concord and reopened it as the Concord Repatriation Hospital. The new hospital offered world class medical, surgical and psychiatric services. The Repatriation Department of the Federal Government also established generous ambulant services for ex-servicemen and their families in the Grace Building in Sydney's CBD. The medical, hospital and psychiatric services offered by the Federal Government were much better than those provided to non-servicemen and their families by the Government of NSW.¹⁷ The superiority of the psychiatric services provided by the Repatriation Department gave clinicians and health administrators who worked outside the Federal Department of Health much food for thought and for critical self-examination.

3.9 Conclusions: A comparison of the evolution of general health services in the United Kingdom and in the Colony and the State of New South Wales

The health services of New South Wales evolved from a British template. When, in 1901, the Colony of New South Wales became a State of the Commonwealth of Australia, the health services provided in NSW were, in many respects, very similar to those in Britain. The customary practices of family doctors, medical and surgical specialists and nurses in NSW resembled those of their British colleagues. The governments of both jurisdictions provided some care for paupers and lunatics. In the first half of the twentieth century the general health services in NSW and in the UK were probably of a similar standard or better than those offered to the citizens of most non-anglophone countries.

The structure and the specific aims of the health care systems of New South Wales and of Britain started to diverge in 1948, when the Atlee Labour Government created the National Health Service (NHS). Under the NHS, the British Government asserted greater control over the British general hospitals. The medical officers and the nurses who staffed the general

hospitals became employees of the British Government and became more directly answerable to it. General practitioners contracted their services to the Government while retaining a pivotal role in the provision of health care throughout Britain. In 1948 the introduction of the National Health Service forestalled the growth, and the potential influence and prosperity, of the private practice of medicine, including the private practice of the specialty of psychiatry. Twenty thousand kilometres from Britain, many members of the Australian medical profession were alarmed by developments in Britain which they considered to be based on misguided 'socialist' philosophies.

After 1901, when the Commonwealth of Australia was created by the federation of Australian colonies, the responsibility for the management of the health and welfare of the citizens of the former Colony of New South Wales were shared by the Federal Government and the State Government, but, in accordance with the provisions of the Commonwealth of Australia Constitution Act of 1900 the medical and hospital services in Australia were primarily the responsibility of the governments of the Australian states. However, during and after the Second World War, the Federal Government assumed increasing responsibility for the management of the health and the social welfare of the nation. The conservative Federal Coalition Government of Robert Menzies, which came into power in 1949, was strongly opposed to the creation of a National Health Service in Australia. Menzies' Government pledged support for the autonomy of the medical profession, and support for private practice and for private health insurance organisations. Coalition governments kept those promises during the next twenty-three years but the Menzies Government could not ignore the fact, in the early 1950s, that there was a crying need for changes in many aspects of social welfare and in the management of mental illness throughout Australia. Between 1938 and 1955 remarkable new biological treatments for severe mental illness began to arrive from Europe.

These treatments included Cardiazol convulsive therapy, electroconvulsive therapy, insulin coma therapy and the antipsychotic and antidepressant drugs. The importance of these new therapeutic agents will be discussed in *Chapter Nine: The impact of new treatments on psychiatric services*. The most famous and important of these agents was known generically as chlorpromazine and by its trade name, in Australia, as Largactil. Towards the end of the 1950s new ideas about preventive medicine, preventive psychiatry and consultation-liaison psychiatry started to arrive in Australia, mostly from the United States. The federal and the state governments of Australia came under enormous pressure from the media, from the voters, and from the medical profession, to reform the antiquated psychiatric services for which they bore responsibility. Psychiatric services in Australia were about to undergo a major revolution.

In the late 1950s the NSW Government was forced to acknowledge that it must create and implement new policies which would foster preventive medicine, preventive psychiatry and community psychiatry. The implementation of those new policies would require a new Mental Health Act. Of equal importance, the State Government needed to put laws into place which would give it the capacity to force the amalgamation of all the staff and all the services which were provided by the general hospitals and the mental hospitals of NSW. The Government also needed the power to appoint clinical staff to work in community settings away from the mental hospitals and from the general hospitals. When those processes were complete it would be possible for the State Government to minister to the general health needs and the mental health needs of geographically delineated communities throughout NSW. The rude awakening of the NSW Government to the need for determined actions and the changes which resulted from those actions are described in *Chapter Eight: Psychiatry in*

the doldrums (1925 to 1961) and in Chapter Ten: A renaissance in psychiatry in New South Wales (1961 to 1994).

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Chapter Four

Moral treatment and medical therapeutics during the nineteenth century

4.1 Introduction

Chapter Four describes the invention and the application of the psychosocial modality of therapy called ‘moral treatment’. For most of the nineteenth century, in advanced industrial nations, moral treatment was generally regarded as the orthodox treatment for serious mental illness. This chapter traces the movement of ‘moral treatment,’ and the system of mental asylums associated with that treatment, from Britain to the Colony of New South Wales. The chapter also outlines the role of medical ‘therapeutics’ in the mental asylums of the nineteenth century.

4.2 The management of insanity in New South Wales: 1788 to 1900

During the first decades of the penal colony of New South Wales, the principal motivation for attending to insanity was to maintain order and to protect the persons, possessions and properties of the colonisers. Between 1788 and 1811, individuals who were deemed to be insane and at risk of destructive behavior towards themselves or others were usually detained in gaols. In 1811, Governor Macquarie ordered that a disused military barracks at Castle Hill should be converted to contain the colony’s lunatics. In 1814, he instructed the manager of that institution that the inmates of the Castle Hill Asylum should be managed with ‘mildness, kindness and humanity’. This may have been the first official expression of humane advice concerning the management of insane persons in NSW.

Because of their prior medical training and experience in Britain, the various medical men who provided services at the mental asylum at Castle Hill between 1811 and 1826 (William Bland, Henry Ravenscroft and then Thomas Parmeter) and the mental asylum at Liverpool between 1826 and 1839 (Patrick Hill), followed practices in the management of insanity that had been imported from the British Isles. Dr Patrick Hill and the lay superintendent of the asylum at Liverpool, Thomas Plunkett, managed the inmates in the converted parsonage at St Luke's Hospital in Liverpool according to the principles of moral treatment. Toby Raeburn and colleagues assert that:

Well suited to the environment provided by the church parsonage at Liverpool, moral treatment promoted gentleness, benevolence and compassion, and was delivered in a physical environment that encouraged spiritual reflection.¹

In 1838, the inmates of the Liverpool Lunatic Asylum were transferred to the purpose-built Tarban Creek Lunatic Asylum at Gladesville. The superintendents of the mental asylums at Castle Hill, Liverpool and Tarban Creek between 1811 and 1848 were not medical practitioners. The first medical superintendent of a mental asylum in NSW was Dr Francis Campbell. Campbell was able to supplant the lay superintendent of Tarban Creek Lunatic Asylum, Joseph Thomas Digby, and, in 1850, to completely oust him.¹

Campbell, who had medical qualifications from Glasgow and Edinburgh, and who had migrated from London in 1839, had extensive knowledge of the therapeutic practices then employed in the management of insanity in Britain. Campbell held the position of medical superintendent at Tarban Creek until 1867. He was a strict disciplinarian but was strongly opposed to the use of physical restraints. Campbell had a forceful and belligerent character and was criticized on many counts. Nonetheless, he was equally critical of his opponents as well as of the Government of NSW. He was a strident advocate for the asylum management

of mental illnesses, arguing for the creation of smaller asylums in country areas, and against larger asylums in Sydney. In some respects, Campbell differed from many other advocates of moral treatment. For example, he was strongly opposed to dances and outings for his patients and did not encourage visitors to his asylum.^{2,3}

For more than one-hundred and seventy years after 1788, New South Wales imported British ideas and practices concerning psychiatry, making modifications to suit the local society and geography. A comprehensive account of the asylum era lies well beyond the remit of this dissertation. The reader who seeks a fuller account of the inception and development of the asylum system in the Northern Hemisphere might start by reading accounts of the asylum era in France and in Britain in the late eighteenth century.⁴⁻⁶ The motives of contemporaneous governments, societies, lawmakers and psychiatrists in the creation and maintenance of mental asylums are disputed. Consequently, scholarly interpretations of this era are diverse. Readers may wish to turn to the work of Richard Hunter and Ida McAlpine, German Berrios, Hugh Freeman, Roy Porter, Kathleen Jones, Michel Foucault and Andrew Scull, but readers will not find a consensus about the motives that underlay the asylum era.⁴⁻¹³

4.3 The inception of moral treatment and the asylum era

Towards the end of the eighteenth century, British intellectuals were profoundly interested in the revolutionary social and political changes that were happening on the other side of the English Channel. During the 1780s and 1790s, the physician Jean-Baptiste Pussin and his successor at the Bicêtre Hospital, Phillippe Pinel, introduced a more humane approach to the treatment of insanity than had existed prior to those decades. The two Parisian physicians sought to distinguish their method from its harsh predecessors and, in 1790, Pinel dubbed their approach '*traitement moral*'. In the parlance of the era, '*moral*' held two meanings:

‘psychological’ and ‘ethical’. For Pinel and his contemporaries, the term *‘traitement moral’* therefore implied a humane approach towards to the management of the mentally ill as well as a psychosocial modality of therapy. Pinel argued that mentally ill persons should no longer be managed like brute animals; they should be treated as human beings who deserved respect. Despite their insanity, individuals were understood within the *traitement moral* approach to retain the potential for rational thought and behaviour. It was understood that they could, and should, be guided back into sanity and towards the social and other rewards to which all human beings were entitled. Carers were instructed to avoid unkindness and unnecessary restrictions or punishments when dealing with mentally ill persons, and to allow them to move about as freely as possible. The physical structure of care also changed under this approach. Dungeons were replaced by sunny, well-ventilated rooms with access to pleasant courtyards and gardens. Pinel visited his patients very frequently, in some cases several times a day. He engaged them in conversations that he hoped they would experience as enjoyable, educational and therapeutic.

4.4 Mental asylums in Britain

‘For about 150 years’, wrote the British historian Kathleen Jones, the mental asylums of Great Britain ‘represented the main means of psychiatric care and treatment.’⁸ Throughout her work, Jones argued that the primary motivation underpinning the creation of lunatic asylums was one of beneficence. In taking this stance, she disagreed with the proposition that had been advanced by social theorist, Michel Foucault: that the mental asylums were created to control unruly elements in the population. According to Jones:

The decision to set up asylums arose out of the problems of workhouses and prisons. It was not a means of incarcerating a new section of the population, but

of making better provision for people who were already institutionalised, and in much less suitable conditions.⁸

In support of this interpretation, Jones pointed to the fact that those deemed to be lunatics and idiots and who had no one to protect their welfare, were mostly to be found in poorhouses, workhouses or prisons. Impecunious lunatics faced such horrendous challenges to survival that most of them would have welcomed access to meagre shelter, sustenance and care.

According to British law, lunatics and idiots who were ‘found’ within the boundaries of parishes became the responsibility of Poor Law overseers. Those overseers were themselves answerable to local justices of the peace for their performances as managers of paupers. In the late eighteenth century, lunatics who were found outside their own parishes without any means of support could be convicted of vagrancy and imprisoned. Jones argued that the introduction of the system of lunatic asylums was the consequence of campaigns by religious and secular idealists—the evangelicals and the Benthamites—which eventually led to the passage of the County Asylum Act of 1808. This Act was followed, between 1811 and 1845, by the construction of eleven lunatic asylums across England and Wales. Among those asylums were three in the Home Counties adjacent to the city of London. The story in Scotland was similar.

Moral treatment, as Oliver Sacks suggests, was taken up by those ‘high-minded individuals and philanthropists’ who searched for better ways to manage the social problems caused by madness:

In the absence of specific medications for mental illness at this time—“moral treatment”—a treatment directed towards whole individuals and their potential for physical and mental health, not just a malfunctioning part of their brain—was considered the only humane alternative.⁹

The construction of mental asylums also provided an option for the containment of criminal lunatics—persons convicted of criminal offences but deemed to be insane and therefore less legally responsible for those offences. It was clearly inappropriate, even to 19th century lawmakers, to hold criminally insane persons in workhouses or in conventional prisons. Kathleen Jones’ analysis of the social forces and events surrounding the asylum era in Britain are generally applicable to New South Wales (NSW), with two key caveats.^{8,10} Because NSW was established as a penal colony, large sections of the population were already under the command of, or containment by, the Governor such that liberty was not a prominent feature of life in the early decades of the colony. Secondly, NSW did not import the Poor Law system, which meant that it had no parish poorhouses or workhouses. As a small society shaped by forced or free migration, it was rare that indigent lunatics and idiots would have recourse to a family member or a friend with sufficient resources to support them.¹⁴ If incarceration—for either shelter or security—were judged necessary, the only institution that was always available was the gaol.

4.5 The York Retreat and the County Asylums Acts

While Pinel and his colleagues were employing *traitement moral* at the Bicêtre, a parallel approach to the humane treatment of the insane was being developed in England, at the York Retreat.¹⁵ The Retreat, an institution for the voluntary care of the insane, was established in 1796 by the Society of Friends. Its reputation soon became as favourable as the reputation of the existing York Asylum was poor. Indeed, the abuse suffered by one member of the Quaker community within the York Asylum prompted the Quakers to open the new institution. The best remembered founding member of the Retreat was the businessman and philanthropist, William Tuke. Treatment at the York Retreat was based on psychosocial rather than medical

principles.¹⁵⁻¹⁷ There was a great emphasis on the therapeutic potential of communications and other interactions between staff and patients that were based on love, kindness and on close attention to religious dimensions of living. Residents of the Retreat were considered akin to members of a large family. They were encouraged to enjoy the relaxed atmosphere, the gardens, the sunlight and the air, and to accept all opportunities for social interaction. It was believed that friendly and encouraging social interactions would improve the mood of the patient. Such encounters would lead to better self-esteem, more positive attitudes and better social behaviour. The ultimate goal of management was to educate patients so that they would acquire moral strength, moral purpose and self-confidence.¹⁵⁻¹⁷ Among the patients, those who were well enough might engage in farm labouring for exercise and as a form of occupational therapy. Some of the philosophies that underlay the success of the Retreat were soon assimilated by the quickly developing British system of mental asylums.

Careful attention to the siting and the appropriate architecture of lunatic asylums were among the keys to moral treatment because, in addition to securely retaining their involuntary inmates, government-funded asylums had to provide a physical setting where moral treatment could be put into practice. Moral treatment was only theoretically feasible if there were healthy, pleasant and spacious interiors, sunny courtyards and gardens and large rooms fitted out to allow patients to be educated in social and occupational skills. The pathway of the asylum era, however, in Britain and elsewhere, was seldom without theoretical and practical hazards. In 1815 and 1816, a British Parliamentary Select Committee examined the management of public and private institutions for the care of the insane. A review of the Committee's proceedings by the historian William Bynum reveals that the rationales for the management of insanity applied by medical men and lay superintendents were often inconsistent. There was considerable agreement that moral treatment was an essential part of

the therapy of insanity but, as Bynum argues, medical men often had contradictory motives for bringing medical manoeuvres into the therapeutic regimes of their institutions:

Professional, social and economic considerations coloured their own judgments and tempered the enthusiasm they showed towards moral therapy. They were prepared to adopt many of the features of the York Retreat into their own therapeutic programs. They were not prepared to jettison their medical models of insanity, nor were they willing to compromise their central roles in the diagnosis and treatment of the mentally ill. They were successful in establishing the medical specialty of psychiatry.¹⁸

4.6 The place of medical treatments—otherwise known as ‘therapeutics’—in the management of mental illnesses

During the asylum era the role of therapeutics was more varied and more contentious than the role of moral treatment. Those therapeutics included opiates, emetics, purgatives and a wide variety of other drugs, as well as baths, setons, and bloodletting. All those measures had their advocates and their detractors. In most respects, the therapeutics designed for mental illnesses had the same rationale as the therapeutics that were employed for the treatment of physical illnesses. That rationale was based on the second century Galenic idea that the humoral balance of the patient should be restored by bloodletting, purging or emesis.

The 1860s were the heyday of mental hospital psychiatry. In 1860 a greatly respected British alienist, Dr Forbes Winslow, who ran two private mental asylums in Hammersmith, proclaimed:

It is a well-established fact that 70, if not 80, per cent of cases of insanity admit to easy and speedy cure, if treated in the early stage, provided there is no strong

constitutional predisposition to cerebral and mental affections; and even when an hereditary taint exists, derangement of the mind generally yields to the steady and persevering administration of therapeutic agents, combined with judicious moral measures, provided the first scintillations of the malady are fully recognised, and without loss of time grappled with, by remedial treatment.¹⁹

In 1867, young Dr Norton Manning, a neophyte in alienism, commenced a study tour of the world's best-known lunatic asylums. He was favourably impressed by the programs of moral treatment that he observed on this tour, and carefully reviewed them in his *Report on Lunatic Asylums* (1868).²⁰ By all accounts, Manning's contemporaries judged him to be a wise, honest and measured witness and observer (see *Chapter Five: Lunacy services in New South Wales in the late nineteenth century.*) Therefore, although he had no significant experience as a medical officer in a mental asylum, Manning's *Report* concerning the asylums which he visited, and the therapeutic programs which they employed, deserves close study.

Importantly, his *Report* lacks any details about the 'persevering administration of therapeutic agents' which were employed in those asylums. This suggests that Manning was more impressed by the utility of psychosocial measures than the use of medical therapeutics.

Seventeen years after Norton Manning's study tour, and after his own extensive survey of the mental asylums of the world, his contemporary and fellow Australian psychiatrist, Dr George Tucker, wrote his own extensive review of mental asylums called *Lunacy in Many Lands*.

Tucker concluded his review with this very important observation:

Judging from the returns of cured in various countries, it will be seen that the proportion of recoveries is about the same in most well conducted institutions, **where moral and hygienic measures are alone relied on, and that the proportion is not altered by the most elaborate medical treatment, but that**

the rate of cures is greater where no restraints are used, and where quietness and good management are principally relied on, as is the case in small well organised institutions. [Emphasis by the author of this dissertation].²¹

4.7 The main elements of moral treatment in the 1890s

According to the medical historian William Bynum, the most authoritative guide to psychiatric diagnosis and treatment in Britain in the late nineteenth century is Daniel Hack Tuke's *Dictionary of Medical Psychology* (1892).²² According to Bynum, it offers 'a unique window into the late 19th century profession'.²² The *Dictionary* described psychiatric management under two main headings: *Treatment (General)* and *Therapeutics*.^{23,24} Under the heading of *Treatment (General)*, Hack Tuke discussed those aspects of management not related to the use of medical agents. The *Dictionary* advised that newly admitted patients should initially be encouraged to rest in bed – particularly those who suffered from melancholia and for other less debilitating presentations of depression. Excessive mental work or 'over-study' were often cited here as the cause of mental collapse, and a period of mental rest was encouraged in response.²³ Once the effects of exhaustion were overcome through a period of sustained rest, argued Hack Tuke, it was important to distract patients from their internal worlds by various manoeuvres, amusements and daily exercises. 'If idleness is a curse to the sane,' the *Dictionary* informed, 'it is the parent of mischief and ennui to the insane, and especially to the pubescent and adolescent cases. The lives of the idle insane are miserable and without interest.'²³

It was important, then, that asylums of the time should provide organised activities, including outings, dances and outdoor games. It was also important to displace 'insane ideas' by supplanting them with 'new and healthy thoughts' and to revive familiar habits and daily

routines. This, it was thought, would restore self-respect and remind patients of their skills and strengths at the same time as it promoted their physical health. Outdoor activities were especially desirable for the restoration of body and mind, but indoor occupations such as painting and printing also had a place in therapy. The *Dictionary* noted that some, but not all, authorities emphasized the merits of schooling. In this part of the *Dictionary*, the author approved of the use of asylum chaplains to superintend educational activities and suggested that the 'companions' of patients should encourage them in reading and conversation.²³

The *Dictionary* advised that an appeal to reason could sometimes succeed when other measures failed:

It has been laid down over and over again that it is of no use to attempt to argue an insane man out of his delusions. As a general rule this is no doubt true, but it may be too broadly stated and too invariably acted upon. The rule may hold good at one stage and be no longer applicable at another. At any rate it is certainly a duty to make the experiment of bringing actual facts to bear upon the delusion under which the patient labours.²⁵

Entries in the *Dictionary* concerning seclusion and restraint strongly emphasized that restrictive practices should be minimised but conceded that they were sometimes unavoidable.²⁶ Unwanted behaviour could mostly be controlled by providing enough trained attendants to physically hold the most violent patients rather than by using straitjackets or other physical devices. But, advised the *Dictionary*, in some instances it might be better to employ a strait-waistcoat than order manhandling by an attendant to whom a patient might attribute more 'personal animosity.'²⁶

Florid mania was the most difficult condition that was faced by alienists in the late 1800s.

The *Dictionary* included the following advice:

In no branch of lunacy practice has more advance been made in recent years than in the treatment of the maniacal condition. Violent purgation, and free depletion [bloodletting], which were once esteemed panaceas, on the supposition of that affection was symptomatic of the of sthenic inflammation are now as obsolete as the swing-chairs and the surprise baths of a somewhat earlier period, methods which no doubt rested on the implicit assumption that excitement is the result of a moral and not a physical aberration. More recently the practical difficulties which attend the management of mania were too often met by the prolonged use of seclusion and by the stupefying effects of calmatives and narcotics. The dangers attendant on the indiscriminate use of both of these methods are now at length fully recognised by alienist physicians. The first great indication in dealing with a case of mania is to procure rest. In the majority of cases this can undoubtedly best be effected by treatment in an asylum.²⁷

Under the heading of *Treatment (General)* the *Dictionary* made very little reference to medications but, in four pages of the *Dictionary*, under the major heading of ‘*Therapeutics*,’ the *Dictionary* discussed the use of opiates and other drugs.²⁸ Those other drugs included the ‘sedatives’: chloral hydrate, paraldehyde, bromides and sulphonal. The *Dictionary* stated that opium could be useful in cases of acute mania and in cases of melancholia, but only if administered with great caution. ‘Monstrous doses have been given but that practice is reprehensible’.

The *Dictionary* also offered extensive advice about the use of counterirritants, tonics, diet, exercise, warm baths and the importance of restful sleep. Under the heading of ‘*Therapeutics*’ the *Dictionary* did not describe the urgent treatment of agitated or violent patients by using drugs, which begs the question whether the episodes of agitated and violent psychosis that have become commonplace in the emergency departments of modern metropolitan hospitals occurred less frequently in the mental hospitals of the nineteenth century. It is clearly the case that stimulant street drugs are implicated in many of the episodes of psychotic excitement that are now seen in emergency departments of general hospitals. In the opinion of the present author, if episodes of psychotic excitement were as frequently seen in the mental hospitals in the 1890s as they are now seen in many psychiatric settings, their management would have received detailed attention in the *Dictionary*.

Throughout the nineteenth century, emetics and purgatives were commonly prescribed in mental asylums in the belief that toxins in the alimentary canal could cause insanity, just as they were thought to cause a multitude of physical illnesses. The rationale underlying ‘bloodletting’ or ‘depletion’ was the physician’s desire to restore humoral equilibrium. ‘Depletion,’ informed the *Dictionary* in 1892, ‘is rarely justifiable.’²⁹

4.8 The use of nineteenth century drugs as an adjunct to moral treatment during the asylum era

The term ‘chemical restraint’ was used in the 1990s and 2000s to describe the processes by which psychotic and violent patients were controlled in emergency situations in many medical settings, including emergency departments and psychiatric units in general hospitals.³⁰ Several contemporary historians have asserted that ‘chemical restraint’ was also regularly employed in mental asylums during the nineteenth and early twentieth centuries to

produce a more tranquil and compliant hospital environment. According to Fennell in Britain, and Roth in Australia, opiates, bromides, chloral hydrate, paraldehyde and several other drugs were often also used for that purpose in the late nineteenth century.^{31,32} In 2018 Roth wrote: ‘The extent of relatively cheap chemical restraint, and analysis of the prohibitive labour costs of using physical restraint to achieve control on the same scale strongly suggest that sedatives were an essential enabler of the rapid growth of asylums in the new age of moral treatment.’³²

Roth takes this argument even further, stating that this rapid growth of asylums ‘...could not have been achieved without the cheap technology of chemical restraint.’³³ I would contend that Roth overestimates the capacity of these nineteenth century drugs to control psychotic behaviour or to produce a calmative effect on the environment within the mental hospitals. This is not, however, to dispute that opiates, bromides, chloral hydrate and other ‘sedatives’ were used very excessively in some wards of mental hospitals, globally and in Australia. For example, in his autobiography, Dr AT Edwards, who had been the medical superintendent of several mental hospitals in New South Wales, wrote that, in the female wards of Callan Park Mental Hospital in the late 1930s, and unlike other wards and other mental hospitals in which Edwards had worked:

On the female side two thirds of the patients were to all intents and purposes chronically drunk. For months, and in many cases years, they had regularly been given three times a day a concoction known as *Mist Cereb Sed.* containing in each dose 15 grains of chloral hydrate, fifteen grains of bromide and fifteen minims of tincture of opium.³⁰

However, to be ‘chronically drunk’ is not the same as being ‘tranquillised’. The nineteenth century ‘sedatives’ induced drowsiness, stupor and confused thinking rather than orderly thinking and calm and rational behaviour. The effects of most of those contemporaneous

drugs would usually last for a few hours and could not be kept at a uniform level by repeated dosage. The differential between the dosage that caused soporific effects and the dosage that caused coma and death was dangerously small. The effects of repeated doses of bromides were more prolonged because bromide accumulates in the blood stream. This goes some way to explaining why patients would be described as possessing a state of ‘chronic drunkenness’.

The excessive use of ‘sedatives’ in the wards of nineteenth century mental hospitals would not necessarily have turned those wards into more tractable, rational and calm places. Those drugs have little or no ameliorative effect on troublesome psychotic processes, such as delusions, hallucinations and psychotic behaviours. The effects of the ‘sedatives’ of the nineteenth century are not comparable to those of the modern antipsychotic drugs, such as the butyrophenone and phenothiazine classes of drugs, from which we get the generically known chlorpromazine and haloperidol. There are major differences between the pharmacological effects of the drugs that were prescribed in the mental asylums prior to 1955, and the antipsychotic agents which became available after that date.³⁵ Daniel Hack Tuke clearly articulated the limitations of nineteenth century drug treatments for insanity when, in 1881, he made his first Presidential address to the members of the Medico-Psychological Association:

It must be frankly granted that Psychological Medicine can boast, as yet, of no specifics, nor is it likely, perhaps, that such a boast will ever be made. It may be difficult to suppress the hope, but we cannot entertain the expectation, that some future Sydenham will discover an anti-psychosis which will safely and speedily cut short an attack of mania or melancholia as bark an attack of ague.³⁶

The absence of antipsychotic agents prior to the middle of the twentieth century is of crucial relevance to the history of psychiatry. If an ‘anti-psychosis’ had become available in the nineteenth century, then it is highly likely that the movement of psychiatry into the general hospitals, and the remarkable changes in psychiatric treatment and psychiatric services that occurred in the 1960s, would have happened many decades earlier. The discovery and the introduction of modern antipsychotic agents is discussed further in this dissertation in *Chapter Nine: The impact of new treatments on psychiatric services* and in *Chapter Ten: A renaissance in psychiatry in New South Wales (1961 to 1994)*.

4.9 Conclusions: Moral treatment at the beginning of the twentieth century

Although, at the end of the nineteenth century, lip service was still paid to moral treatment, there was no substantive evidence that it was effective. The mental hospitals were overflowing and the atmosphere within them was very grim. The elected governments of Western jurisdictions, including that of New South Wales, tried to shrug off accusations that the mental asylum system was in an impoverished state. It was shameful that those governments took shelter behind the defence that they did not have the funds to keep pace with admissions. Those governments exploited the fact that the critics of the mental asylums could not suggest a credible alternative program for the management of cases of potentially self-destructive or potentially violent insanity. Therefore, at the commencement of the twentieth century, mentally ill persons who could not find refuge in family care, or in expensive private care, continued to be certified as insane and forced into the mental hospitals. They went there in the often vain hope that they might find some benefit from whatever care, kindness and therapeutic measures might be provided within the walls of those institutions.

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Chapter Five

The management of insanity in New South Wales in the late nineteenth century

5.1 Introduction

Chapter Five describes the development of the psychiatric services of New South Wales during the last third of the nineteenth century and sets the scene in 1898 prior to the entrance of psychiatric services into any of the general hospitals of New South Wales. In 1898, the man most responsible for the performance and the reputation of the psychiatric services of NSW was the first Inspector-General of the Insane for NSW Dr F Norton Manning. Manning had commenced his psychiatric career as the Medical Superintendent of the Tarban Creek Lunatic Asylum in 1868, a year that was pivotal in the narrative concerning the evolution of the psychiatric services of NSW. Manning's career, and the status of psychiatric services of NSW between 1868 and 1898 were inextricably blended.

5.2 Dr Norton Manning at Gladesville Hospital for the Insane and then as Inspector-General of the Insane for New South Wales (1868-1898).

In 1867 Dr Norton Manning, a young naval surgeon who was visiting Sydney, on board a British warship called the 'Esk', met the Colonial Secretary, Mr Henry Parkes. Parkes needed to replace the retiring medical superintendent of the Tarban Creek Lunatic Asylum, Dr Francis Campbell, and offered the position to Manning. Manning accepted and, in October 1868, after an eleven-month study-tour of mental asylums in England, in Europe and in the United States, took up his duties at Tarban Creek. Between that year and 1897 Manning was the most influential psychiatrist in New South Wales and arguably, in Australia. Although he

could never overcome the threat that overcrowding posed to conditions in the mental hospitals of NSW, Manning had a remarkably successful career. Between 1868 and 1877, Manning converted the Hospital for the Insane at Gladesville from a primitive and prison-like institution into a well-managed late nineteenth century mental hospital.¹ In January 1876, while retaining his role as the medical superintendent of that mental hospital, Manning was formally appointed as the Inspector of the Insane for New South Wales. He continued in both roles until September 1879, when he became the first Inspector-General of the Insane for New South Wales, a position that he maintained until 1897.² In that newly created statutory office, Manning was effectively the executive director of all the mental health services of New South Wales.

Of course, no director of a psychiatric service can make headway without the genuine support of the government to which he is answerable. A factor that greatly contributed to Manning's success in creating a modern mental health service was the backing that Manning usually received from Henry Parkes. Between 1856 and 1891 Parkes wielded great power in New South Wales where he was often either the Colonial Secretary or the Premier of the State.³ Before the creation of a Ministry of Health in 1914, the Colonial Secretary was the government minister in charge of hospitals, prisons and asylums. The relationship between Parkes and Manning developed from one that had commenced with their shared interest in the governance of health services and in other health-related and community issues. That relationship changed, over many years, into a 'close friendship' and was usually strong despite Manning's complaints about his salary and his repeated and frank complaints to the Legislative Assembly about the Government's tardiness in attending to the needs of the mental asylums and to the patients therein.⁴

5.3 The mental health system of New South Wales between 1868 and 1898

In 1868 there were two permanent lunatic asylums serving a widely dispersed population of about 400,000 colonists. The Tarban Creek Lunatic Asylum had first admitted patients in 1838; in 1868 it held close to 650 residents but only had accommodation that was adequate for 300 persons.⁴ When Manning took up his duties as its medical superintendent, he renamed it the Hospital for the Insane at Gladesville. The other lunatic asylum, at Parramatta was not initially Manning's responsibility. It had been created, in 1848 by the conversion of a factory that had given employment to female convicts. That asylum was divided into two sections: a Free Asylum containing over 700 inmates and a Criminal Lunatic Asylum, purpose-built in 1861, which contained close to sixty beds. The Free Asylum was mainly used for the management of chronic cases of insanity and was in a dreadful state. In 1876, when he took up his additional appointment as the Inspector of the Insane for NSW, Manning described the Parramatta Asylum as '... the worst in Christendom' and wrote that he had not seen 'anything so unsatisfactory and so saddening—except at Cairo.'⁵ The Reception House at Darlinghurst, which had opened in 1868, only had sixteen beds. It provided rapid assessment and triage of patients who were entering the public psychiatric services of NSW. Within a fortnight of their entrance into the Reception House, most of them would be transferred to one of the colony's mental hospitals as certified patients.⁶ However, a minority would have recovered from their mental disturbance and been discharged from psychiatric care. In 1865, the first licensed privately owned mental hospital in NSW had opened at Tempe, about eighteen kilometres to the south of Sydney Cove. That institution, which was owned and managed by Dr George Tucker, was not a commercially viable private enterprise but was able to survive by an arrangement between Tucker and Manning that allowed the transfer of dozens of easily managed patients from Tarban Creek—now renamed the Gladesville Hospital for the Insane.

By this arrangement the Licensed House at Bayview was able, by 1876, to accommodate 135 patients, 130 of whom were women.⁷

In 1871, the Newcastle Asylum for Imbeciles and Idiots was created by the conversion of the Industrial School for Girls. Shortly afterwards, the Newcastle Asylum accepted the transfer of one hundred patients from the overcrowded wards of Parramatta Mental Hospital. Callan Park Mental Hospital, which was designed by the Government Architect, James Barnet, assisted by the advice of Norton Manning, opened in 1878. In 1897 Callan Park Hospital would be accepting more acute psychiatric admissions than any other mental institution in NSW. Rydalmere Psychiatric Hospital opened in 1888 on a site previously occupied by an orphanage and then accepted the transfer of chronically mentally ill patients from Parramatta Mental Asylum. The construction of Kenmore Mental Hospital, near Goulburn, commenced in 1894; the hospital began to accept patients in the following year, many of them from the southern regions of the State.⁸ (See List One: Mental Hospitals of New South Wales).

Throughout his two decades as Inspector-General of the Insane, Manning repeatedly complained about overcrowding in his Annual Reports to the Legislative Assembly. Those complaints were often broadcast by the local newspapers. For example, in 1878 an article in the *Cumberland Mercury* commented on the overcrowding and deteriorating conditions in Parramatta Lunatic Asylum and reported on Manning's efforts to persuade the NSW Government to address a problem that was not diminishing. 'Dr Manning complains bitterly of the great overcrowding of all the lunatic asylums of New South Wales, which he says must greatly militate against their efficiency.'⁹ In Manning's Annual Report for 1896 he advised that the likely cause for the increasing rates of admission to his mental hospitals was the economic depression that had followed years of severe drought. In 1896 the ratio of certified

patients to the population of NSW was 1 in 337, or 2.96 per thousand which, he said, was not very different to the proportion of the population certified as insane in Britain. There were now 3,845 patients residing in the six mental hospitals and three licensed houses of New South Wales and another 59 persons were on leave but were still registered as certified patients according to the provisions of the Lunacy Act.¹⁰ Manning recorded that, in December 1895, there had only been accommodation in his mental hospitals for 3,409 persons but that his Department of Lunacy had been responsible for 3,798 certified patients. This meant that there had been 389 more patients than his hospitals could properly accommodate. Manning then vented his concern about the poor conditions in the wards of his hospitals, instancing overcrowding and a social environment that was not therapeutic and was sometimes dangerous.

The wards at Gladesville, Callan Park and Parramatta were at the close of the year in a dangerously overcrowded condition, and a more than usually anxious charge to the Medical Superintendents, the excessive number of patients interfering seriously with the management, tending to quarrels and accidents and militating against the physical health and the mental restoration of the inmates.¹⁰

Despite the failure of the NSW Government to keep pace with the need for accommodation and therapeutic activities within in its mental hospitals to match the rapid growth in the population of the Colony, the reputation of the mental hospital system in the late nineteenth might have surprised a time-traveller from the twenty-first century. Cummins opined: 'In the latter half of the nineteenth century that the reputation of the [NSW] asylums was high.'¹¹

Edwards and Shea agreed, and accorded considerable credit to Manning:

By the time he retired from this position in 1898, [Manning] had transformed the [psychiatric services] into services that were as good as, if not better than, many

of the best services overseas and had established himself as a leading expert in his field, recognised as such both nationally and internationally.¹²

5.4 The laws concerning lunacy in New South Wales between 1868 and 1898

In 1868, when Manning commenced his duties as the Medical Superintendent at Gladesville, the Dangerous Lunatics Act of 1843, with minor amendments, was still in force. The 1843 Act required the certification of insanity by two medical practitioners but was heavily slanted towards the exercise of powers by judges, by justices of the peace, by magistrates, and by the police. Manning was the main architect of a new Lunacy Act of 1878 (42 Victoria No 7) which was proclaimed in 1879. Manning's role in the design of this legislation has been emphasized by Shea and by Cummins.^{13,14} The latter noted: 'Norton Manning was the influential person behind the drafting of the Act, and many of its provisions relate to his comparative study of lunacy laws during his [1875] study tour.'¹⁴ An important consequence of the 1878 Act was the creation of the office of Inspector-General of the Insane for New South Wales—an office of great responsibility and power that Manning would come to occupy on 4th September 1879. Additional Amending Acts were pulled together in 1898 in a Consolidating Act. The Acts were so well framed that they survived, with minor modification, until 1958. The Lunacy Act of 1878 and its amendments removed many aspects of criminality in the 1843 Act and attempted to remove the option that had allowed the police to hold suspected lunatics in jails while they awaited further processing. The abandonment of those features of the 1843 Act reduced some of the stigma associated with insanity and was destined, in the next century, to make it easier to create a foothold for psychiatry in the general hospitals of NSW.

According to the 1878 Act it was not legally possible to admit any person as a voluntary patient to a mental hospital in NSW but there is good evidence that Norton Manning believed that it would eventually become legally acceptable to admit patients voluntarily to mental hospitals. Under the heading 'Voluntary patients', Cyril Cummins wrote, in 1979:

Although voluntary admissions to mental hospitals are now the rule, the concept was well known to the early Inspectors General and advocated by them. In 1886 Norton Manning reported on the need to separate socially paying and those of higher education and social status as a therapeutic measure to aid their recovery. He lamented that due to overcrowding the only classification of patients was psychological but perhaps in the future a ward could be set aside at Gladesville and cottages built at Callan Park.¹⁵

There were provisions in the 1878 Act that were intended to allow later legislation to permit general hospitals to care for the insane on a temporary basis. An authority on the history of mental health legislation in NSW, Dr Graham Edwards, commented on this aspect of the 1878 Act: 'On this latter matter eighty years would elapse before any systematic development of general hospital psychiatric units were to occur in NSW.'¹⁶

5.5 Unresolved difficulties concerning the management of insanity in the country regions of New South Wales in the late nineteenth century

Between 1868 and 1878, while he was converting the institution at Tarban Creek from a prison-like asylum into a modern hospital for the insane, Manning travelled widely throughout NSW to ascertain how insane persons were being detained and managed. He visited courts and jails and interviewed magistrates and policemen. He observed the problems that arose in country towns where persons who were judged by the police or by justices of the

peace to be insane could not be placed anywhere other than in prisons. This was because the boards of country hospitals repeatedly refused to accept mental cases pending their transfer to the mental hospitals in Sydney and Parramatta. Manning's travels and investigations equipped him to draft certain features of the new Lunacy Act which he hoped would make it easier to overcome those difficulties. Section 48 of the Lunacy Act of 1878 (42 Vic No 7) offered the general hospitals the opportunity to come within the ambit of lunacy law by making it legal for them to temporarily hold and to manage certified patients who were awaiting transfer to the mental hospitals in Sydney and Parramatta. In his Annual Report for 1880, Manning stated that Section 48 of the 1878 Lunacy Act had made legal provision to set apart wards in public hospitals 'for the temporary reception and management of insane persons' but that, with the initiative left with the committees controlling general hospitals, no public hospital in NSW had taken up that option'.¹⁷ The problem had not abated in 1882, when Manning reported:

While insane patients in and near Sydney now have advantage of care and treatment in the Reception House in the early stages of their malady, those living in country districts have still no other refuge other than the prisons; and the arrangements in all these which I have had an opportunity of seeing, including those at Bathurst, Goulburn, Maitland, Mudgee, Albury, and Armidale are very ill adapted for the reception and care of insane persons.¹⁸

In the last third of the nineteenth century, the population of NSW was widely dispersed throughout the State. Country patients often had to pass through jails on their way to mental hospitals. For instance, 16 patients were admitted for treatment and 13 were lodged for a day or two at Maitland; 11 were admitted for treatment and 21 received temporary shelter at

Bathurst and 9 were admitted for treatment and 18 were lodged for a day or two in a jail at Goulburn. Manning commented further:

I think it much to be regretted that at these important centres at least, some movement to provide special wards for the insane in connection with the general Hospitals has not been commenced. The 48th Section of the Lunacy Act provides for the establishment of these wards, but leaves the initiative to the Committees of the Hospitals. In the neighbouring Colony of Victoria such wards have been built at five of the Country Hospitals, and the Committee are repaid by the Government all expenses incurred in the treatment in them.¹⁸

Manning added that, in the more remote and sparsely populated districts of NSW, the prisons would, for many years to come, remain the temporary refuge for cases of insanity that required care. However, he believed that the gradual extension of the railway had already rendered the transfer of these cases to Sydney more rapid and easy. Manning carefully framed two amending laws that allowed magistrates to remand cases of mental illness to general hospitals and reception houses (Amending Acts of 1879 and 1881). At the end of the nineteenth century, patients from rural areas of NSW were still forced to undergo confinement in country jails before they could be transferred to mental hospitals. In that respect the management of psychiatric patients in rural New South Wales contrasted unfavourably with management in Victoria, where the general hospitals in five country towns participated in the management of insanity. In most respects, the lunacy services in the Colony of Victoria resembled those in New South Wales but there was one notable difference. For varying periods, after 1869, 'lunacy wards' existed at five general hospitals in Victoria. These wards, which were all legally gazetted by the Victorian Government to hold insane persons, were at Castlemaine, Geelong, Bendigo, Woods Point and Sale. The wards at

Wood Point and Sale were used very little and closed within a few years.¹⁹ The wards at Castlemaine, Geelong and Bendigo may have served a useful purpose and survived until the next century. According to the former Deputy Chairman of the Victorian Mental Health Authority, CRD Brothers, the eventual failure of the Victorian lunacy wards resulted from two factors: the junior medical staff of the hospitals were not sufficiently interested in the management of insanity and the nursing staff were inexperienced and lacked the required training. Brothers does not mention the participation of qualified psychiatrists in the management of patients in those lunacy wards. In the opinion of the present author, it would be surprising if any of those wards had achieved their intended purpose without the control and supervision of those wards by medical practitioners who had some training in, and who were committed to, the optimal management of the mentally ill.

5.6 Norton Manning's reputation and its relevance to the history of general hospital psychiatry after 1898

In the late nineteenth century Norton Manning garnered an excellent reputation for himself and for the specialty that he personified as the leading psychiatrist of NSW. That reputation was a great asset for psychiatry—one that would help psychiatry to find acceptance in the general hospitals of NSW in the twentieth century. Throughout his career Manning was regarded as a leader of society in New South Wales. He was very active in the medical, academic, social and intellectual life of the Australian colonies. Manning was on close terms with the leading academic physicians Normand MacLaurin, Alfred Roberts and Anderson Stuart.²⁰ Manning was a principal founder of the Royal Prince Alfred Hospital, where he earned an outstanding reputation by his contributions to its creation and management in its early years.²¹ According to William Epps, a historian of RPAH, the main force behind the early success of the hospital was Sir Alfred Roberts, assisted by several key figures:

...among the foremost [of the medical men] was Dr. Norton Manning, a man of high ideals and intellectuality, who for many years co-operated whole-heartedly with Sir Alfred in the work of designing and managing the hospital.²²

The first patients were admitted to RPAH in 1882 and the first medical students entered its wards in 1884. As a member of the Faculty of Medicine, Manning automatically had the right to consult on patients admitted to RPAH. Unfortunately, there are no surviving records of the earliest admissions to RPAH and therefore no opportunity to check whether Norton Manning provided psychiatric consultations.

Immediately inside the main entrance of RPA Hospital, there is a prominent white marble bust of Manning, with the caption 'A Founder.'



Figure 1. Bust of Dr Frederick Norton Manning inside the main entrance to the Royal Prince Alfred Hospital. Courtesy Audiovisual Department, Royal Prince Alfred Hospital.

In 1883 Manning was appointed as the first Examiner in Psychological Medicine and in 1886, he became the first Lecturer in Psychological Medicine at the University of Sydney—a role he maintained until 1888. In the *Journal of Mental Science* for April 1890, Dr Daniel Hack Tuke, who was then one of its Editors, published abstracts of two papers presented by Manning at the Second Intercolonial Medical Congress of Australasia together with the examination paper for undergraduate medical students that had been prepared by Manning. Hack Tuke noted that Manning had recently relinquished his lectureship at the University of Sydney.²³ Manning's relevance to the University is acknowledged by a bas relief of Manning's profile over a doorway of the MacLaurin Hall of the University. Manning's is the only likeness displayed in the Hall that does not portray a full Professor of the University. Manning wrote many professional papers and reports and published more than a dozen scientific papers in medical journals. These included a paper on aboriginal insanity that described thirty-two observed cases, the causation of which he attributed to 'civilisation and its accompanying vices'.²⁴ He also published papers on the causation and prevention of insanity; on the question whether insanity was increasing; on the certification of insanity; on head injuries; on the role of heredity in insanity; on the diagnosis of insanity; on insanity and the law; on cretinism (hypothyroidism); on the treatment of the inebriate and on the treatment of epilepsy. He contributed to Daniel Hack Tuke's internationally respected *Dictionary of Medical Psychology*. Manning was prominent in the program of the Second (1889) and Third (1892) sessions of the Intercolonial Medical Congress of Australasia. He chaired two sessions and presented two papers in 1889: one on aboriginal mental illness and one on sporadic cretinism (hypothyroidism).²⁵ Manning was frequently approached by governments and courts for his expert advice on medical and medico-legal issues. For a time, Manning was the Emigration Officer for Port Jackson. In 1882, he was appointed to the Board of Health, and between 1889 and 1892 he was the President of the Board and Medical Advisor to the

Government of New South Wales—roles of great influence and prestige. It was noted earlier in this chapter that many of these appointments were not related to his specialty area of psychiatry. He was asked for expert advice by the Governments of NSW, Victoria, Tasmania and Queensland. The opinions that he provided on legal cases were sometimes published by the Australian print media. Manning implemented systematic training for the attendants and nurses at the Hospital for the Insane at Gladesville, and as Inspector-General of the Insane, he established in-service training programs throughout the lunacy service. He assisted in the creation of the Australasian Trained Nurses Association and was its first President (1899-1902). Several testimonials regarding Manning's contribution to nursing education were published by senior representatives of the nursing profession. Manning was elected to the Royal Society of New South Wales in 1876 and was elected Chairman of its Medical Section in 1883 and 1884. He gave public lectures and wrote for non-medical publications concerning the prevalence and the causes of insanity.²⁵

Throughout the thirty years of Manning's career in NSW, lunacy and general medicine remained separate domains, but ones that he navigated with great ease and success. Near the end of the nineteenth century Manning had, by his professional and personal example, raised the status of psychiatry within NSW. In 1898, thanks to Manning, Eric Sinclair would inherit a Department of Lunacy, that was well administered and respected despite increasing overcrowding in the mental hospitals. For three decades, Manning had amassed a capital of goodwill and respect towards the medical specialty of psychiatry. Without that capital Sinclair would have had less chance of success in his campaigns to allow voluntary admission to mental hospitals and to establish a foothold for psychiatry in the general hospitals. Unlike Sinclair, it seems that Manning never formally advocated that incipient

cases of mental disorder should be managed as voluntary patients in general hospitals. In that respect Manning remained, to the end, an orthodox alienist.

Manning died in 1903 and was interred in the grounds of the Gladesville Hospital for the Insane. Manning had maintained strong ties with his British colleagues, including Daniel Hack Tuke, and was deeply steeped in British medical, psychiatric and other traditions. Manning was British but he also identified as a New South Welshman. As NSW was an important part of the British Empire, Manning would have seen no problem in being both a New South Welshman and a British subject.

5.7 Conclusions

In the late nineteenth century, New South Wales was an important antipodean colony within the British Empire. Its citizens often looked towards the mother country for guidance and inspiration. In most respects the psychiatric services and practices of New South Wales resembled those of Britain but there were several points of differentiation. The Colony had grown rapidly throughout the century and the NSW Government had never quite kept pace with the needs of an expanding population. Secondly, because the mental asylums in Sydney and Parramatta were very distant from other centres of population in NSW, it was difficult to provide mental health services for persons in country regions. The Inspector-General of Mental Hospitals for NSW, Dr Norton Manning, had striven to persuade the boards of general hospitals in country areas to assist in the management of this problem by temporarily accommodating mentally disturbed persons in general hospitals but the general hospitals absolutely refused to cooperate in the management of insanity. At the end of the century, psychiatrists in NSW, and in other jurisdictions, were very concerned that their mental hospitals were overflowing and that the outcomes of moral treatment and medical

therapeutics were not matching the therapeutic outcomes that psychiatrists had predicted in earlier decades.

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Chapter Six

New Proposals for Psychiatry for a New Century

6.1 Introduction

Chapter Six describes the advent of new ideas concerning the management of incipient cases of mental disorder that aroused great interest when discussed and debated at professional meetings in the first decade of the twentieth century in Melbourne, Edinburgh, Liverpool and Sydney. At those meetings the participants agreed that the earlier identification and treatment of incipient insanity was very desirable and would significantly reduce the failures of moral treatment and the overcrowding in their mental hospitals. However, they did not agree about the most appropriate venue for the admission of those cases. Some argued in favour of general hospitals but others argued, with equal passion, in favour of reception houses and mental hospitals. All agreed that psychiatric outpatient clinics should be established at general hospitals. None suggested that mental hospitals would ever lose their role as the principal venues for the management of cases of established insanity or that mental hospitals would ever be abolished.

6.2 The shared international perspective of psychiatrists circa 1900

Towards the commencement of the twentieth century, psychiatrists in Australia were members of a medical fellowship that extended throughout the British Empire. Many of them had received their medical training in Scotland or in England. All were influenced by British publications that included the *British Medical Journal* and *The Lancet*. Many followed the proceedings of the Intercolonial Medical Conferences. Some were members of the British Medical Association. At the start of the twentieth century, the leading Australian medical practitioners were alert to major developments in medicine and in psychiatry in the United

States and in Central Europe, but that information was usually channelled via sources that were based in Britain. Medical practitioners who were interested in mental disorders, especially the alienists in the mental hospitals, knew the importance of articles that were published in the (British) *Journal of Mental Science*. At the commencement of the new century, ideas about a possible role for general hospitals in the management of incipient mental disorders were being discussed and debated throughout the anglophone medical profession.

6.3 Melbourne (1902): A medical conference concerning the management of mental cases in general hospitals

At a meeting of the Medical Society of Victoria in April of 1902, a paper on the role of general hospitals in the management of incipient insanity in general hospitals was delivered by Dr J.W. Springthorpe.¹ Dr Springthorpe was a physician at the Melbourne Hospital and an Official Visitor to the metropolitan mental asylums. In this paper, Springthorpe argued that it would be preferable to manage certain incipient cases of mental disorder in general hospitals than in hospitals for the insane. Springthorpe included, in his paper, a brief account of his management of three mentally disturbed young female patients at the Melbourne Hospital.¹ He commenced by lamenting the quality of the mental asylums of Victoria and their inability to provide optimal care and treatment. He commented on the absence of a reception house in Melbourne and how difficult it was to educate medical students in psychiatry without easy access to mentally disturbed patients. He listed four reasons why certain cases of incipient mental illness should be admitted to general hospitals:

- (1) There is no necessity to wait until some unfortunate accident, lache or crime necessitates the tardily written certificate. Treatment is thus available much

earlier than usual—a point, the importance of which, to the patient, to his friends, and to the community can hardly be over-estimated.

- (2) It places ‘border land’ and early cases under the same therapeutic conditions that have been efficacious against the kindred hysteria, cerebraesthesia, and bodily diseases generally, and it gives the patient greater opportunity of having the frequent co-existing or causative bodily disease promptly and properly attended to.
- (3) It does away with the false distinction between mental and bodily disease, and it altogether avoids the stigma and disgrace attaching to ‘lunatic’ and ‘asylum’.
- (4) There is no signing of certificates with its, at times, serious sequelae to both patients and doctors, and the natural convalescing ground, the home, is much earlier and more readily available.

Nevertheless, Springthorpe was careful to acknowledge certain ‘limitations and disadvantages’ attached to his proposals: (1) There were no cells for management of single cases in general hospitals (whereas single rooms were always provided for their management in mental hospitals); (2) The nursing staff were not organised or trained for lunacy work; (3) The hospital grounds were too small for any recreation; (4) There was pressure to discharge patients and free up beds. (The imperative that patients should be discharged within a few weeks meant that only one of Springthorpe’s patients could be accommodated at any one time at the Melbourne Hospital); (5) There were potential financial costs. Springthorpe insisted that none of these five problems were insuperable.¹ Springthorpe then added certain clinical observations under four headings: (1) It was not possible to deal with cases of mania in general hospitals. (2) It was possible to observe and accurately diagnose cases of suspected

dementia pending confirmation of the diagnosis and transfer of the patient to an asylum. (3) General hospital wards were excellent sites for the observation and diagnosis of many types of ‘doubtful cases.’ These were cases where the relative importance of neurological disorder, psychiatric disorder or transient medical disease processes was unclear.¹ He referred, with obvious approval, to the ‘critical atmosphere of a hospital medical school.’ (4) Springthorpe spoke of other cases which might benefit from admission to a general hospital, including those where insanity was not in doubt but difficulties existed in the processes of legal certification. Springthorpe went on to suggest that many cases of mental disorder resolved within a short time, including cases of inanition, mental confusion and of acute depression. He then presented three brief case vignettes. He then discussed the merits of receiving or reception houses. He argued that the availability of reception houses would be a boon to mental health services in Victoria but that it was also very desirable that certain cases of mental disorder should be admitted to general hospitals.

It is interesting that, in the published transcription of his presentation, it is not recorded whether Springthorpe mentioned the Darlinghurst Reception House in NSW. The Sydney facility had been functioning very successfully since 1868 and was providing medical assessments for newly admitted patients but would not acquire an appended ‘voluntary’ medical ward until 1908.² Springthorpe then cited support for similar proposals to his own regarding the management of incipient insanity by psychiatrists in Britain; he instanced a report in *The Lancet* of a meeting in February, in 1902, of the Edinburgh Medico-Chirurgical Society during which the management of such cases had been discussed.³

6.4 Edinburgh and Liverpool (1902): Innovative proposals concerning the management of incipient insanity

The topic of the management of cases of incipient mental disorders was discussed at length during professional meetings in Edinburgh and in Liverpool. The Edinburgh meeting had been directed by the President of the Medico-Chirurgical Society, Professor T.R. Fraser, to address proposals about the admission of cases of incipient and transient mental disorder to the Royal Edinburgh Infirmary. The Edinburgh meeting was first addressed by Sir John Sibbald, who read a paper which he said had been written at the suggestion of Dr. T.S. Clouston and Dr John Macpherson.³ That contribution by Macpherson to the Edinburgh meeting is of great relevance to the narrative in *Chapter Seven* concerning the introduction of general hospital psychiatry into New South Wales because, exactly two decades later, John Macpherson would arrive in Sydney to accept the foundational Chair of Psychiatry at the University of Sydney.⁴ Some details concerning Macpherson's four years in Sydney are provided in *Chapter Seven*.

The report in *The Lancet* on the Meeting in Edinburgh is relatively brief. It was noted that ten participants in the meeting, including Sir John Batty Tuke, expressed their views. It is not recorded whether there was much opposition to the proposals for the admission of 'incipient cases' into the Royal Infirmary. However, the published account of the Annual Meeting of the Medico-Psychological Association at Liverpool in the *Journal of Mental Science* on July 2nd is very detailed.⁵ That account offers the reader a valuable perspective of the multiplicity of issues that would require careful consideration if psychiatry was ever to enter the wards of general hospitals. Most of the speakers endorsed the proposals listed by the main speaker, Dr Thomas Clouston, but many alienists expressed reservations, and a small number strongly rejected the proposals. Clouston was the medical superintendent of the Royal Edinburgh Asylum and had, for many years been the Lecturer on Mental Diseases at the University of Edinburgh. During his presentation, Clouston offered points for discussion in the format of

sixteen somewhat rhetorical questions.⁵ Those questions are reported in detail in this chapter because of their huge relevance to the global future of psychiatric services during the twentieth century.

1. 'Does any adequate provision exist at present for the right treatment of the early stages of such diseases as have mental disorders for their chief symptoms, or for the slighter and more transient insanities, among the class who come to our general hospitals for advice and treatment?' Clouston responded that the answer must be 'No' because psychiatric services were not provided in general hospitals and it was against the law to send uncertified patients to mental hospitals.

2. 'Is it desirable to supply this want?' Clouston responded that patients with mental symptoms should have the same entitlement to psychiatric care as patients with non-psychiatric complaints. He went on: 'Dr Mott has told us today the extreme importance from the scientific point of view of any form of bad brain habit.' Clouston added that early treatment often arrested or reversed deterioration to certifiable insanity. Should not patients with mental symptoms be spared chronic insanity? Well-to-do patients were able to obtain treatment for their incipient mental disorders. Should not poorer persons share the universal human right to treatment for their mental disorders as well as their physical ailments?

Clouston continued:

To allow such mental symptoms to run to such a degree of disturbance that they can be officially certified as technical insanity seems a cruel neglect, as well as an expensive dereliction of duty on the part of society. For the man so afflicted ceases to be a producer, and becomes incurable.⁵

At present insanity costs the British public about £5,000,000 a year, and increases—largely by accumulation—to the extent of thousands of patients annually, so that now there are 145,000 registered insane persons in the United Kingdom, of whom 133,000 are paid for out of the rates by the industrious portion of the community; and this class of insane persons is increasing at a far greater ratio than the private and richer class.

3. ‘Why should not an extension of the present asylum system fulfil that purpose?’⁵ Clouston answered that the asylum system was not able to provide an appropriate service for cases of incipient insanity because incipient cases were discouraged from seeking help in the mental asylums by the prejudice and stigma associated with those institutions. Moreover, voluntary admission to a mental asylum was not legally possible and no-one wished to be certified as insane.

4. ‘What advantages would the present general hospitals have over asylums and any other mode of treatment?’ Clouston responded that general hospital admission would be preferable to asylum admission for two main reasons. First, the patient would experience no loss of self-respect and no demoralisation. Secondly, the population of Great Britain should be educated, by the employment of general hospitals in mental health care, that there was no essential difference between a mental illness and a physical illness ‘...and that it in no way implies shame or repulsion.’⁵ Clouston instanced the positive community attitudes that had resulted from the good mental health services that were provided to the citizens of Denmark, for nearly forty years, by a psychiatry pavilion at the Copenhagen General Hospital.

5. 'Would not this provision simply be an extension of the of the recent specialisation in medicine and in surgery that have been provided for in the modern hospital with such admirable results in the past fifty years?'⁵ Clouston's answer was affirmative.

6. 'Would not the cost of such provisions be too great?' Clouston responded that each bed in a general hospital cost the state £50 to £100 per year. He estimated that the cost of a psychiatric bed would not greatly exceed that of a medical bed and would scarcely come up to the average cost of a surgical bed.⁵

7. 'Would it imply extensive structural alterations in the present style of a hospital ward?' Adaptations of general hospital design should not be difficult. All the design changes needed were one or two single bedrooms associated with each ward, with special baths and a small amount of day-room space. Clouston quoted the advice of Sir John Sibbald and Dr John Macpherson that most of the cases of incipient insanity would be kept in bed most of the time they were in hospital. [This is an interesting prediction. It suggests that, in 1902, psychiatrists envisaged a very medical model of psychiatric management in general hospitals that left very little physical space for the introduction of psychosocial treatments].

8. 'Would the treatment of such cases not be attended by the risk of disturbing other patients in the hospital?' Dissertation⁵ Clouston opined that this could be avoided by the careful selection of cases and by avoiding the admission of persons who might cause disruption.

9. 'Would the general administration of such ward be so different from the administration of ordinary hospitals that it would complicate and upset the whole internal workings of the institution?'⁵ Clouston answered 'No' and cited the experience of several Scottish mental

asylums that female nurses could manage most cases without difficulty and without serious accidents.

10. 'Would not such wards need special staffs?'⁵ Clouston responded that the medical and nursing staff would need special training, as they would for any medical or surgical specialty. 'All we ask is that the same principle should be applied to mental disease.'⁵

11. 'Assuming that there would be a need for a time limit, say six weeks or two months, to the stay of those patients in such wards, just as there is in the case of most ordinary medical and surgical patients, would such comparatively short periods be sufficient for effective treatment?' Clouston opined that an admission for six to eight weeks was probably optimal. 'In the cases of those who got worse, or in whom the symptoms were prolonged, we have the asylum to fall back upon.' He added:

I have found that out of the ordinary certified patients 10 per cent recover, and are discharged within six weeks; 20 per cent, within two months. A much larger number treated in the earlier stage for the milder form of disease would recover; and many could safely leave the hospital to complete their recovery at home. If you have broken the bad brain habit, if you have successfully contended by proper treatment with the worst symptoms, the patients would safely go home to complete their convalescence.⁵

12. 'Are there actually in existence so many patients in any community whose mental condition makes this treatment, apart from asylum treatment, urgently needed, and would such patients come to hospital to be so treated?' Based on his professional experience in private practice Clouston suggested that about 20 percent of his private patients needed, and

might accept, voluntary inpatient care in a general hospital. He thought that the poor would accept voluntary treatment in general hospitals as readily as would the rich.

13. 'How would such provision affect the knowledge and experience of treating mental diseases possessed by the medical profession?' Gains would quickly become apparent in the education of medical students and general practitioners. The gains would be immense and would flow on to improved services for the public. 'It is probably of more importance to the patient to have early symptoms in mental disease properly treated than is the case in almost any other disease.'⁵

14. Was it not in the public interest to attempt the experiment of speedy identification and treatment of mental symptoms in general hospitals? Clouston restated his conviction that the earlier identification and treatment of mental symptoms, assisted by the willingness of the public to seek the assistance of a well-informed medical profession, would 'sensibly diminish the amount of mental disease in the country.'⁵

15. 'Why did the mental wards in the old hospitals fail?' Clouston answered that the essential element in the success of general hospital admissions is the initiation of treatment at the earliest possible or 'incipient' stage of the disease processes. The earlier experience of failure [such as at Guy's Hospital] was with advanced and therefore 'unsuitable' cases. Moreover, said Clouston, the earlier attempts to create mental wards were with 'limited means' and 'unscientific nursing'.⁵

16. 'What would be an ideal provision for treating mental diseases among the poor?' In Clouston's opinion four provisions were required:

First, a mental ward in the [general] hospital for incipient, transient, and suitable cases. Second, a reception hospital for certifiable cases of an acute character situated near a large town, with plenty of nurses and plenty of medical attention. Third, an ordinary asylum for cases which run on month after month. Fourth, a boarding-out system for the really quiet and manageable cases, who could be restored in a modified degree to family life.⁵

Fifteen of the attendees at the meeting are reported as responding to Clouston's propositions. It is instructive to note that the majority wholeheartedly agreed with Clouston but it is equally instructive to read the views of those who did not.

Sir John Sibbald, who had been a Commissioner for Lunacy for Scotland, was not an alienist, in the sense that he was not an asylum doctor, strongly endorsed Dr Clouston's proposals. He said that the views of Dr Clouston, as a highly respected alienist, were exceedingly important. Sibbald added a qualification that Clouston had probably exaggerated the difficulties associated with admission to general hospitals but Sibbald agreed that severer cases of insanity could never be managed in general hospitals. Sibbald emphasized that nurses and physicians in general hospitals would require special training in the management of mental cases.

Dr Rayner, who was an alienist, supported Sibbald and Clouston. He stressed the value of outpatient clinics at general hospitals, especially for their potential to diminish the stigma of psychiatric disorder and to enhance the prospect of eventually introducing inpatient care into general hospitals. Dr Newington took a negative stance: he opined that it might not be easy to move the attitudes of those who controlled general hospitals to the point where they would

accept Clouston's proposals. Country general hospitals were not big enough to warrant wards for incipient cases of insanity. Newington believed that proper treatment usually took about five months. Admission to general hospitals for 6-8 weeks was insufficient; three months would be more realistic. Dr Brush spoke about his observations during his visits to Germany and to the USA. Details of Brush's comments were not documented in the report in the *Journal of Mental Science*. Dr Savage was sceptical about general hospital psychiatric admission, feeling that the management of insanity jeopardised the other functions of a general hospital. Rest in bed was useful but beds in large city hospital were not quiet and 'restful'. Savage thought that earlier experiments at Guy's Hospital had not gone well. He acknowledged the advantages of general hospitals for teaching medical students but said those advantages were outweighed by disadvantages to the patients and to the general hospitals. Dr Davidson agreed with Dr Clouston's proposal but thought the maximum duration of admission should be three weeks. Dr McDowall thought that it would be many years before Dr Clouston's proposals would come to pass. He favoured opening outpatient clinics at general hospitals and attempts to encourage the education of the general community in matters relating to mental health. Dr Mould was against psychiatric admissions to general hospitals. He favoured asylum care or a system like that in Germany, where there were colonies for the mentally unwell adjacent to country asylums. Patients in those colonies could receive psychiatric advice as outpatients of those asylums. Dr Mould revealed that many patients admitted to his own asylum had never been certified. Dr Urquhart agreed with Dr Clouston's proposals but thought that the duration of admission should be a fortnight before a decision was made about triage to an asylum or discharge to the patient's home. Dr Hyslop differed markedly from Clouston. He claimed that they had the best system at the Bethlem Royal Asylum (St Mary Bethlehem in London). He thought that physicians in general hospitals over-diagnosed physical factors as causative of psychosis and that better psychiatric

management was available in asylums than in general hospitals. He agreed that there was a great need for outpatient clinics at general hospitals. He conceded that a small minority of cases might be managed in general hospitals, but he noted that many general hospitals were reluctant to admit and to treat mental cases. Therefore, he would concentrate on improving mental hospitals and liberalising the ways in which patients were admitted. Dr Bruce argued that general hospital admission for incipient cases was desirable for three reasons: it would curtail episodes of severe mental illness; it would allow psychiatrists to closely observe the manifestations of their patient's disorders; it would allow the education of the medical profession about mental disorders. He added that he strongly approved of psychiatric outpatient clinics.

Dr George Robertson, who later became Professor of Psychiatry at Edinburgh, asserted that Dr Savage was mistaken in his opposition to general hospital care. He suggested that Dr Savage did not realise that Dr Clouston's proposal only applied to incipient cases and that established cases of insanity would automatically go directly to an asylum. In general hospitals, incipient cases had the opportunity to have prolonged bed rest, which was very desirable for their condition. Single rooms were not needed at general hospitals if the hospital rostered enough night staff to provide appropriate patient care. General hospital nurses were usually female, which Robertson thought advantageous.

Dr Yellowlees opposed general hospital admissions. 'The proper place for truly incipient cases is a hospital for nervous diseases where people could go of their own accord. There would be about such places none of the obloquy about which attaches to a "madhouse"'⁵ At Glasgow they had a reception house in the city and two asylums in the country—which he thought an ideal arrangement. Many cases were discharged from the reception house within

two to three weeks. Dr Nathan Raw argued that a reception house where all forms of mental disorder could be readily managed for a short time was the best option for the management of incipient cases. The President of the Medico-Psychological Association [Dr J Wigglesworth of the Rainhill Asylum] opposed general hospital admission except for very select incipient cases, and then only for a short time—usually less than six weeks. Like Dr Yellowlees, he favoured the use of clinics like those in Germany, perhaps superintended by professors, and associated with mental hospitals situated a few miles out of town.⁵ It should be noted that Dr Brush had suggested, earlier in the same meeting, that there might be merit in following the example of Germany by creating psychiatric academic clinics in Britain that resembled those in Germany. These clinics, which usually contained between 60 to 120 beds, would only deal with acute cases of mental disorder, and would rely on the rural mental hospitals for the management of chronic cases of insanity. However, it would transpire that psychiatric services in Britain were not destined to duplicate psychiatric services in Germany and that large academic psychiatric clinics would not appear in any of the British cities before the 1930s. Questions concerning the influence of successful innovations in German psychiatric services on the trajectory of psychiatric services in Britain, and in Australia, will be further addressed in *Chapter Thirteen: Defence of the thesis*.

6.5 Sydney (1911): Innovative proposals concerning general hospital psychiatry during the ninth Australasian Medical Congress

In Sydney, in 1911, there were three presentations at the ninth Australasian Medical Congress that brilliantly illustrate the interest of the Australasian medical professions in these new ideas. These presentations were by Dr Sydney Montgomery, the Inspector General of Insanity for Western Australia, by Dr Andrew Davidson who read a paper on behalf of Dr

Montgomery Asher of Albany, New York State and by Dr Eric Sinclair, the Inspector-General of Mental Hospitals for New South Wales.

Dr Sydney Montgomery, who was the Inspector General of Insanity for Western Australia, gave a presentation titled 'Care of the Suspected Insane in General Hospitals'.⁶ The Lunacy Act of Western Australia (1903) contained provisions concerning the admission of persons who were suspected of insanity into general hospitals. According to Montgomery the Act allowed mentally ill persons to be admitted to a general hospital by an order from a justice of the peace, but those patients could not be detained for more than fourteen days unless the medical officer of the hospital certified in writing that the patient was not in a fit state to be removed. That hospital medical officer was legally obliged to present such a certificate to the visiting medical officer on his next visit. Fourteen days would allow time for the performance of adequate physical and mental health assessments and for early clinical management. By the fourteenth day the hospital medical officer was legally obliged to decide whether to discharge the patient or to certify him or her to a mental hospital. It was also possible for patients to be admitted voluntarily, without the order of a justice of the peace, to the same facility. In 1908 a building containing a male and a female ward had been constructed adjacent to Perth's main hospital. This project was mainly funded by the Lunacy Department of Western Australia, which provided the male nursing attendants. Montgomery informed that, in the financial year of 1909, 118 patients had been admitted into this facility, of whom 98 were males and 20 were females. In 1910, 127 patients were admitted, of whom 104 were males and 23 were females. Montgomery was delighted to report that, during those two years, 103 out of the 212 admitted males and six of the 43 admitted females 'were spared the stigma of insanity'. By this he meant that 109 of those 255 persons had avoided certification of

insanity and admission to a mental hospital. For the successive years the discharge rates were 54 percent and 47 percent.⁶

Montgomery then listed the advantages afforded by early admission of probable cases of insanity to a general hospital rather than to a reception house or to a mental hospital. A very large proportion of these cases would not be truly insane, or their insanity would be of a temporary character, often caused by alcohol. Secondly, the fact that a man or woman might be admitted to a reception house, or to a mental hospital or might be cast into a gaol, would ruin their reputation and their future social and occupational prospects. A third reason was that many of the suspected insane were not insane but were 'mentally run down'. The fact that they were admitted to a general hospital would not adversely affect them, whereas the shock of the knowledge that they have been admitted to a reception house, a mental hospital or a police cell, might be a final challenge to the strength of their sanity. Fourthly, it was undoubtedly true that medical graduates and trained nurses were ignorant about mental diseases and that this was a very unacceptable situation. 'How many of our trained nurses have ever seen a case of insanity? How many would be capable of attending to a case of puerperal mania?'

Montgomery then acknowledged that there might be objections to his proposals and offered the following responses. To the objection that mental 'patients would disturb other patients in the hospital' he replied:

In practice this is not so. ... These cases are in a separate ward. They are not noisy and violent cases as these would be sent straight away to the Hospital for the Insane, the diagnosis being clear, the only exceptions being alcoholic cases,

and these are admitted every day to hospitals under the diagnosis of delirium tremens.⁶

The second objection was that the hospital staff were not properly trained to manage these cases. Montgomery's preferred solution was that male nursing staff should be employees of his Lunacy Department but that the female nursing staff should continue to be employed by the general hospital, but those female nurses should now have a chance to learn about mental diseases. This was the arrangement that had been established at Perth Hospital. A third objection was that mental cases were better managed by consultant psychiatrists.

Montgomery conceded this possibility, but not in cities like Sydney and Melbourne where there would be honorary physicians attached to general hospitals who would be willing and able to manage such cases. A fourth objection, that an extra expense would be borne by the general hospital had been overcome in Western Australia, where the Lunacy Department met those expenses. The last theoretical objection, that general hospital authorities and Departments of Lunacy might have difficulty working together was answered by Montgomery: '...this is a matter which should not be allowed to stand in the way of a reform which is undoubtedly a step in the right direction.'⁶

The second paper of great relevance to general hospital psychiatry that was presented at the Australasian Medical Congress in 1911 was delivered by Dr Andrew Davidson on behalf of its author in the USA, Dr Jesse Montgomery Mosher. Mosher was the Director of an exciting clinical experiment that had been under way for nine years in Albany, New York. Mosher had published a paper on the subject in 1900 but was now able to report the outcomes of that experiment.^{7,8} In 1902 a facility that was intended for the voluntary admission and management of cases of incipient insanity had been created in Albany, NY. The service was in a two-storey building that housed 31 beds and was annexed to the Albany General

Hospital—a 360 bed major general hospital. The new psychiatric facility was funded from three sources: by an endowment, by the payment of fees for private service and by public funds on a per capita basis for patients who could not afford payments.

Patients were admitted at their own request, for observation and treatment and for a determination of the advisability of their commitment to institutions for the insane. If a patient demanded to be released or declined to co-operate with the treatment, and it was safe to release him, he was immediately released. If there was doubt about the capacity of the patient to act responsibly, his family, friends or public authorities were notified and they would remove the patient or begin legal proceedings for commitment to an institution for the insane. The principles of treatment were based on physical and mental rest, dietary measures, warm baths and various drugs and herbs. Some attendance at the bedside by family and friends was encouraged. Nurses were trained to spend as much time as they could at the bedside in order that they could make observations and attempt to educate the patient. This educative process included the family and friends of the patient.

Acute cases of mental disorder follow a long departure from normal physical health, and the active symptoms are an incident in a protracted course of neurasthenia. The duty of the hospital is the removal of this complication and the education of the patient in its causes, its cure and its prevention.

In the nine years of the existence of this psychiatric facility at Albany, 2,000 patients had been admitted, of whom 1,000 had been restored to their homes and occupations. According to Mosher, there had been no private or public complaints concerning the services rendered, or any improper detention or disregard of the civil rights of patients. According to Mosher the experiment at Albany had proved to be an unqualified success.

The third presentation of relevance to general hospital psychiatry at the 1911 Australasian Medical Congress, was by Dr Eric Sinclair.⁹ In 1911 Sinclair had held the office of Inspector-General of the Insane for New South Wales for thirteen years. Sinclair presented the results of a survey that he had circulated to over 500 general practitioners in NSW in which he sought their opinions about the early treatment of mental disorders. The responses to Sinclair's survey will be discussed in the next chapter of this dissertation.

6.6 Conclusions

At the start of the twentieth century, psychiatrists could not ignore or deny the fact that moral treatment in mental asylums had not proved to be the panacea for insanity that Forbes Winslow suggested it to be in 1860.¹⁰ The mental hospitals were overflowing and the outcomes of therapy were disappointing. In early years of the twentieth century, leading psychiatrists in Britain, America and Australia were focussed on ideas concerning the management of incipient mental disorders. All psychiatrists believed that prompt treatment of incipient mental disorder would lead to better therapeutic outcomes and fewer patients in their mental hospitals but they did not agree about the place where those patients should be managed. Those psychiatrists who favoured treatment for incipient insanity in the wards of general hospitals had the support of several leading general hospital physicians, including John Springthorpe in Melbourne and Sir John Sibbald in Edinburgh. The dissenting psychiatrists agreed that psychiatric outpatient clinics should be established at general hospitals but wished to go no further down any pathway towards general hospital psychiatry. They listed many reservations, but several stood out: First, they argued that the general hospitals would never tolerate the disruptive behaviours of psychiatric patients. Secondly, the staff of the general hospitals lacked the clinical expertise, or the patience required to properly

diagnose and to manage the problems of persons who became seriously mentally ill. Thirdly, any movement of psychiatric services into the wards of general hospitals would diminish the resources and the status of the mental hospitals and would limit their capacity to provide optimal treatment for mental illness. It is noteworthy that none of the attendees at those four professional meetings are reported as suggesting that moral treatment would ever be discarded as an essential modality of therapy for severe mental illnesses. None of them suggested that a radically new and effective medical treatment for insanity might be discovered. None of them suggested that mental hospitals would ever become obsolescent and deserve to be closed.

During the four professional meetings that were reviewed in this chapter, identical problems of psychiatric management were discussed without any significant reference to local issues. There was very little to differentiate the main concerns of psychiatrists in Melbourne and Sydney from those in Edinburgh and Liverpool. It is also important to note that, in 1911, Australian psychiatrists were interested in the psychiatric innovation in general hospital psychiatry in Albany, New York.

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Chapter Seven

Under the leadership of Dr Eric Sinclair, psychiatry commences its entrance into the general hospitals of New South Wales

7.1 Introduction

The era of general hospital psychiatry began in New South Wales in 1898 with the appointment of Dr Eric Sinclair as the second Inspector-General of the Insane. During the next twenty-seven years Sinclair would introduce a series of reforms directed towards two principal goals: the acceptance of voluntary procedures as a common means of admission to mental hospitals and the projection of psychiatry into the heart of general medicine by the creation of a Chair of Psychiatry at the University of Sydney and the creation of beds for psychiatric patients in the medical wards, and of a psychiatric outpatient clinic, at the Royal Prince Alfred Hospital. Chapter Seven describes and discusses these events.

7.2 Eric Sinclair becomes Inspector-General of the Insane for New South Wales and a new era in psychiatry begins

In February 1898, Eric Sinclair inherited command of the mental health service of NSW. A less able and less experienced psychiatrist-administrator would have been daunted by the thought of comparison with his predecessor, Dr Norton Manning. However, Sinclair confidently pursued his own plans for the future of psychiatry in NSW. Sinclair's tenure followed a flurry of new ideas within the global medical community concerning the management of cases of incipient mental disorders. Sinclair was determined to select and to implement the best of those ideas in NSW.

Sinclair had been born in 1860, in Greenock West, about 25 kilometres from the centre of Glasgow. The son of a presbyterian minister, he was educated in a nearby provincial school and then at the University of Glasgow, whence he graduated as a Bachelor of Medicine and Bachelor of Surgery in 1881. Within a year, he had migrated to NSW and was appointed as a medical officer at the Quarantine Station at the entrance to Sydney Harbour. Within another year, Sinclair was a medical officer at the Hospital for the Insane at Gladesville. By 1884, he was the medical superintendent of the same hospital. In 1899, he succeeded Dr Manning as Inspector-General of the Insane for New South Wales, a title that was then converted to Inspector-General of Mental Hospitals.

7.3 Overcrowding as an issue in the mental hospitals of NSW

Manning had retired during 1897 and left the task to Sinclair of writing the Annual Report of Inspector-General for that calendar year.¹ In that Report, Sinclair alerted the Government that, whereas the rate of admissions to the mental hospitals of NSW had previously remained stable, admissions had escalated between 1892 and 1897, but that the rate of admissions had not risen as rapidly in NSW as it had in Britain.¹ In his Report for 1899, Sinclair noted that there were 3,998 patients in his mental hospitals but accommodation for only 3,911—a discrepancy of 87 beds.² Sinclair advised that a new hospital was needed at Orange to provide easier access and admission for persons from the western regions of the Colony. Building extensions were already under way at Kenmore and at Rydalmere but an additional hospital was ‘absolutely necessary’ at the ‘earliest possible date’.² The Government was dreadfully slow to act on Sinclair’s advice. Bloomfield Hospital at Orange would not become operational prior to 1925.²

In his Report for 1900, Sinclair requested amendment to the Lunacy Act.³ He stated that most of the provisions of the Act applying to patients already committed to the mental hospitals were satisfactory, but:

It is found, however, that some greater facility for admission of patients whose insanity has not yet reached the stage at which it can be certified is advisable, and the plan embodied in the Lunacy Act of Scotland of voluntary admission appears to best meet the end desired. Under this Act a patient whose insanity is not, as yet, too pronounced may, on a written request by himself, be admitted to and detained in a hospital. He cannot, however, be detained for more than three days after he expresses his intention or desire to leave, and he must be seen on each visit by the Commissioners in Lunacy [...] The want of such a provision is frequently felt here, patients having repeatedly come to the hospital for treatment and been disappointed at the inability to admit them.³

Sinclair's focus on the early treatment of 'patients whose insanity has not yet reached the stage at which it can be certified'—otherwise known as a case of 'incipient mental disease'—would remain a preoccupation throughout his career. Other Sydney physicians, including Dr Andrew Davidson, the Medical Superintendent of Callan Park Mental Hospital and Dr George Rennie, a physician in private practice who held an honorary position at the Royal Prince Alfred Hospital (hereafter RPAH), were similarly vocal about the need for earlier identification and treatment of mental disorders, and for the creation of a voluntary psychiatric facility in Sydney. However, Sinclair was in the best position in NSW to effect the desirable changes.

In 1901, Sinclair reported that steps had been taken to open a second reception house in NSW at Newcastle.⁴ This reception house would commence services in 1902. In paragraphs about the lack of reception houses and triage in country areas, Sinclair described how he had striven to persuade the hospital committee of an unnamed country town that, rather than have mental cases detained in the local gaol until they could be transported to a mental hospital, patients should be managed in the wards of the local hospital. Sinclair had assured the relevant hospital committee that any related processes would be paid for by the Government.

Sinclair's frustration at the refusal of the hospital committee is evident in his Annual Report:

It is to be regretted that the Hospital Committee persistently raised objections to the proposals, and finally wrote absolutely declining to undertake the responsibility. It cannot but be felt that in taking up this position, which strongly accentuates a distinction between those affected by mental diseases and cases of ordinary sickness, the community is losing sight of the humanitarian view that the insane, because of their affliction with this distressing disease, should be treated as cases of ordinary illness, and not be prisoners or outcasts.⁴

In the same Annual Report, Sinclair asked the Government to act on his previous suggestions that the Lunacy Act should be amended to allow legal provision for the acceptance of voluntary patients into his mental hospitals.⁴ In 1902, he reported that the number of admissions to his mental hospitals was the largest ever and predicted that increasing numbers of admissions would occur in the future. He complained that although he and Manning had repeatedly stressed the need for additional buildings to accommodate the existing numbers of patients, the Government had taken little action. Sinclair cautioned that, within a year, all the beds in his institutions would likely be occupied, and that newly admitted patients would have to sleep on make-up beds in the passageways and dayrooms.

Both in the daytime and at nights the result will be a difficulty of supervision and invite an accident, and an absence of comfort and those conditions for careful treatment that patients have a right to expect. The space provided in the dormitories and day-rooms is the minimum permitted by sanitary authorities, and a real danger to health will ensue when more than the proper number is placed in them.⁵

Sinclair added that new acute care wards were particularly needed at Gladesville and Rydalmere Hospitals.⁵

By 1903, 4,105 patients were resident in the mental hospitals, whose combined accommodation allowed only for 3,911.⁶ In his Annual Report for this year, Sinclair attributed these increased admissions to the expanding population of NSW and to the 'Federation Drought' that had, by that time, been affecting the state for nine years. Sinclair urged promptness in creating more beds in mental hospitals and warned the Legislative Assembly:

This overcrowding is a serious matter, and if continued will prove fatal to the reputation which has been built up by the Department [of Lunacy] by years of careful work. It is not easy to carry out proper medical treatment in wards where the patients are so closely packed as to compel association with those who might react detrimentally on each other, nor is it easy to avoid accidents due to the irritation thus caused.⁶

A year later, the accommodation problem was worse still, with the number of patients growing to 4,209.⁷ Sinclair chronicled overcrowding in all subsequent Annual Reports, but

with little apparent response from the Government. In his Report for 1905, Sinclair emphasised, in detail, the importance of offering treatment to persons who were at the earliest stage in the development of their mental disorder. He described the possible options for timely treatment. He concluded his analysis by expressing a clear preference for management of incipient insanity in the wards of general hospitals:

Admission to a Hospital for the Insane requires that there should be certain legal formalities, and that the patient should be certified as insane, and it is natural that both patient and friends should shrink from this at the early stages of illness and adopt any method which promises a return to health, without the stigma that would necessarily follow from admission to hospital.

There is, however, no institution at which treatment at this period can be offered, and in too many cases the patient is kept at home, or not treated at all, until his symptoms have become so grave as it is impossible for him to remain longer outside a Hospital for the Insane.⁸

Sinclair then noted that the provision of an admission block at Gladesville and Callan Park would facilitate efficient treatment. These admission blocks would function as separate institutions, to which only recent and curable cases would be admitted, and from which they might be discharged without entering the general institution. In 1905, Sinclair again noted that the law did not sanction admission to mental hospitals without the legal formality of certification. He added that, whereas early treatment in mental hospitals might be as effective as in general hospitals, most patients would avoid admissions to mental hospitals if it would mean avoiding the stigma commonly attached to certification into those hospitals.⁸

7.4 First proposals for a psychiatry ward at RPAH

In his Annual Report for 1905, Sinclair stated that, ‘among the recent and curable cases’ presenting for admission and treatment ‘a large proportion could be treated in the ordinary wards of a general hospital.’⁸ On November 7, 1905, and again on November 14, 1905, the RPAH Medical Board discussed a proposal that would see two wards, each of four beds, allocated to the management of ‘incipient insanity’ and ‘alcoholic cases’.^{9,10} This was part of a larger reappraisal of the use of beds at RPAH, including proposals to expand bed numbers to 400. On the 3rd of September, 1909 the minutes of the Medical Board state: ‘it is agreed the opinion of the Medical Board that it is desirable to establish 2 special wards for the observation of cases of incipient insanity one ward of 4 male beds & one ward of 4 female beds.’¹¹ According to Muriel Knox Doherty, a senior nurse-administrator and a historian of RPA Hospital, there was a delay of three years before the Inspector-General of Mental Hospitals responded that he would not support that proposal, but Knox Doherty does not say why Sinclair withheld his agreement.¹² According to Knox Doherty, in 1914, the Medical Board voted in favour of an allowance of seven thousand pounds for the creation of an ‘isolation ward’ and an educational psychiatric outpatient clinic for the instruction of doctors, medical students and nurses in the management of incipient mental disorders, but she does not report on the outcome of those decisions.¹²

7.5 The Mental Hospital (or Mental Ward) at Darlinghurst

In his 1905 Annual Report, Sinclair proposed the construction of a mental ward adjacent to the Darlinghurst Reception House and described its intended purposes.

It is proposed, however, to erect a ward adjoining the Reception House at Darlinghurst, which will be devoted to patients not yet certified, and who will, therefore, be under the same conditions as in the wards of a general hospital, and this would be of obvious help in dealing with early cases of mental disease. These

steps are not, however, sufficient to take the place of the general hospital treatment, which has several advantages over anything a specialised department can do, one of the greatest of which is placing mental diseases on a plane parallel to general diseases.⁸

The Mental Hospital at Darlinghurst was a small facility very unlike other mental hospitals in NSW. It was constructed to accommodate no more than twenty male patients. It was built with the expectation that many, but certainly not all, of the admissions would suffer from problems related to the abuse of alcohol, but not for the treatment of delirium tremens or other deliria, which ought always to be managed in general hospitals. The medical officers who worked at the Reception House included Drs George Rennie, Andrew Davidson and Chisholm Ross, all of whom had extensive experience in dealing with psychiatric disorders. There was no resident medical officer. The nursing and administrative staff were distinct from those managing the Reception House, except when attention to patients was needed at night. In his Report for 1914 Sinclair wrote:

The mental ward at Darlinghurst opened in May 1908, for uncertified cases of insanity and has accommodation for 20 male patients. The ward is but small, and was established more or less to demonstrate to the general hospitals that such a ward was possible and eminently desirable, as for many years attempts had been made, without success, to induce them to open such a ward.¹³

Acting as an expert witness before the Royal Commission of Inquiry into the Administration of the Mental Hospital and Reception House for the Insane at Darlinghurst, Sinclair told the Commissioners that he had ordered the construction of the small hospital abutting the

Reception House with the intention that it should be ‘used on the lines of a ward of a general hospital’ and that:

There are no legal conditions attaching to admission. Any suitable patient applying or sent with a note from a medical man is taken in and there is no power of legal detention, restraint or control. People are free to leave when they desire.¹⁴

The creation and successful functioning of the Mental Hospital at Darlinghurst is regarded as one of Sinclair’s significant achievements and is very relevant to the development of general hospital psychiatry in NSW in that it demonstrated, as Sinclair had hoped, that certain mentally ill persons could be voluntarily admitted and managed in a setting that resembled a medical ward of a general hospital.¹⁵

7.6 The reluctance of the NSW Government to legislate in favour of voluntary psychiatric admissions

Decades would elapse before the NSW Government would pass legislation to allow voluntary admissions to mental hospitals. The main reason for this reluctance is attributable to the widespread fear that persons who were not insane might somehow be forced into mental hospitals, or, otherwise, that patients in such hospitals might remain there indefinitely. There were many citizens, including some members of parliament, who were concerned that civil liberties would be endangered if there were insufficient legal protections to guard against inappropriate admissions to mental hospitals. Questions about the possibility of wrongful admission were asked at the Royal Commission into the Mental Hospital for the Insane and the Reception House at Darlinghurst in 1913, and at the Royal Commission into Lunacy Law and Administration in 1923.

In 1922, the staff, patients and functions of the small Mental Hospital at the Reception House were relocated to the Broughton Hall Special Hospital. However, prior to the passage of the Lunacy Amendment Act of 1934, it was still theoretically against the law to admit patients who had not been certified insane into any of the mental hospitals of New South Wales.

7.7 Sinclair's survey of the views of general practitioners concerning the management of incipient mental cases (1911)

In 1911, at the Australasian Medical Congress, Sinclair presented the results of a survey concerning the attitudes of general practitioners regarding the management of incipient mental disorders.¹⁶ Sinclair emphasized that the general practitioner, alone, had the opportunity to observe and treat mental disorders in the earliest stages of their development. Of the 500 general practitioners across NSW contacted by Sinclair, there were only 82 respondents. Nevertheless, Sinclair judged that those responses included some valuable information. Nearly all the respondents had opined that that treatment at home in the early stages of mental illness was unsatisfactory, but they were mostly unable to suggest how treatment at home could be made more effective. The majority said that as soon as it was recognised that the case was one of mental disorder, the patient should undergo well-designed treatment in a special type of mental institution, in a reception house, or in a special ward annexed to the local general hospital. GPs also opined that the NSW Government should provide nursing staff who were appropriately trained to manage those patients and should meet all the associated costs. A few GPs suggested that trained mental health nurses might attend patients in their own home, for a fee, as happened in country areas for non-psychiatric conditions. The GPs claimed that the practice of holding suspected mentally ill persons and of certified mentally ill patients in gaols prior to their assessment or their

conveyance to mental hospitals was detrimental to those patients and that such practices should be avoided.¹⁶

Analysing those written responses, Sinclair commented that many respondents had failed to properly address the questions put to them in the survey: they had not distinguished between measures that were appropriate for incipient insanity and those that were appropriate for established, and therefore certifiable insanity. However, Sinclair judged that the responses to questions about the management of all cases of insanity had some value. The GPs generally recommended that, instead of adding wards to general hospitals, it would be better if the Government were to build special mental hospitals, but they acknowledged that this might only be practicable in large centres of population. Sinclair commented that, by and large, the GPs had not made clear in their responses whether they thought that cases should be managed in those special hospitals until the termination of that episode of insanity, or whether the patients should stay in those facilities only until there was an opportunity for them to be certified and forwarded to a hospital for the insane. It seemed to Sinclair that the GPs intended the latter. Sinclair concluded his presentation to Congress:

As a general summary, it may be stated that it has been brought out that general practitioners who deal with the mental cases in the early stages are not prepared to recommend that they should be treated as cases of ordinary illness, either in the patient's home or in the local general hospital; in fact their being admitted to the general wards is resented. It is desired that the cases be treated as special ones, that special hospitals or reception-houses should be provided, that specially trained nurses should be made available, and trained escort for conveyance should be provided. Where the local hospital is mentioned the replies are emphatic that special wards should be added to it before patients are received,

and even here it is stated that specially trained nurses should be supplied. At the same time, it is asked that all this should be done at the Government expense.

There is also an indication of a desire to admit patients for care and observation in the early stages of mental disorder without the formality of fully-signed certificates.¹⁶

Sinclair must have been disappointed that the respondents to his survey often failed to understand that he was inquiring about the management of incipient cases, rather than of overt cases of insanity. He might also have been disappointed that the GPs were so opposed to the management of incipient cases of mental disorder in the ordinary wards of general hospitals. Nevertheless, he pressed on, by several stratagems, to achieve his goal of the introduction of psychiatry into the wards of the general hospitals of NSW.

7.8 Establishing wards for returned servicemen within the grounds of Callan Park Hospital and at nearby Broughton Hall Military Hospital (1915)

Servicemen returning to NSW from the Great War suffering from severe mental disorders were mostly managed in the 28th Australian Army Hospital, located on the grounds of Callan Park Mental Hospital of which it was a part. Adjacent to Callan Park Mental Hospital was a property containing a mansion called Broughton Hall. In 1915, that mansion was converted into a facility for the voluntary treatment of repatriated servicemen. Thus the 13th Military Auxiliary Hospital was established to accommodate and treat cases of ‘shell shock, neurasthenia and slighter mental disorders’, with a separate cottage to accommodate certain cases ‘in which mental disorder is definitely present and cared for.’ The development of this separate cottage marks a particularly important step in the evolution of psychiatric services in

NSW in that it tended to servicemen who were seriously mentally ill but who were not certified as insane. Sinclair wrote: 'It is pleasing that it has been found practicable to treat all cases without recourse to formal certification as insane of any of the patients being necessary,' explaining that the stigma of certified insanity would cause inestimable injury to the prospects of those ex-servicemen. He continued: 'it is a cardinal principle of the New South Wales system that such [formal certification] should be avoided.'¹⁷

7.9 Voluntary admissions to mental hospitals after 1915

In his 1915 Annual Report, Sinclair noted that servicemen being admitted voluntarily to Callan Park were still subject to military law and implied that certification of insanity was therefore not always required to maintain their compliance with treatment. In the introductory paragraph to the same Annual Report, Sinclair wrote that, in anticipation of the enactment of his proposed amendments to the Lunacy Bill to allow voluntary admissions to mental hospitals, forty-eight patients had been admitted voluntarily to his mental hospitals during that year.¹⁷ It seems that the voluntary admission procedures that Sinclair described in his 1915 Report were never subjected to legal challenge, or, if they were challenged, that those challenges were not widely publicised.

7.10 Sydney's major general hospitals consider the need for the creation of voluntary psychiatric wards or for the creation of psychiatric annexes to general hospitals

Under the heading: 'Establishment of a Dept of Psychotherapy at the Hospital' it is recorded in the minutes of the Medical Board of RPAH on 17th Dec 1917, that the Secretary informed the Medical Board Committee that a memorandum concerning the question of allowing psychiatric beds in RPAH had been sent to all the Board members.¹⁸ Dr Rennie addressed the Medical Board at length about this proposal. Drs Gillies, Mills, Sandes, Craig, Morton and

MacLaurin all contributed to discussions that followed. The Board then passed the following resolution:

It is not at present desirable to establish a Department of Psychotherapy unless special accommodation is set apart for that purpose but as the subject is of such importance the Board thinks it advisable that a special subcommittee should be appointed to deal thoroughly with the subject and make recommendations, Drs Rennie, Mills, Gillies and SA Smith.¹⁸

This subcommittee met with the Minister for Health, who suggested that a meeting of representatives of three major Sydney hospitals should be convened to consider proposals about the establishment of an inpatient psychiatric facility at one of Sydney's general hospitals and to advise him about their discussions and their conclusions. That conjoint meeting took place on the 28th of March 1918 at Sydney Hospital. A typewritten account of that meeting is glued to the pages of the minutes concerning the RPAH Medical Board Meeting of 5 July 1918, signed by Dr George Rennie.¹⁹ The account is headed 'RPA Sydney and Coast Hospitals meeting that was held to consider the whole question of the treatment of Psychotherapeutic diseases in soldiers and civilians.'

At that meeting, RPAH was represented by Drs Rennie, Gillies, SA Smith, Mills and Schlink. The first speaker at the meeting told the assembled doctors that the RPAH Directors had asked the Medical Board to consider the possibility of establishing a 'department of psychotherapy'. The RPAH Medical Board complied with that request and responded to RPAH Directors that 'it was not at present desirable [to establish a department of psychotherapy] unless special accommodation was set aside for the purpose' at RPAH.¹⁹

Dr Jervis-Hood (for Sydney Hospital) then pointed out that military cases were all catered for at Broughton Hall. Dr Marshall (Sydney Hospital) noted there was no remaining demand for attention to such cases. Dr Macdonald-Gill (Coast Hospital) stated it was out of the question to build such wards in the metropolitan hospitals. Dr Campbell (Coast Hospital) pointed out that a ward of 20 beds for very similar purposes had been established by the Inspector-General of Mental Hospitals in 1908 'but that its situation [adjacent to the Reception House at Darlinghurst] militated against its success'. Dr Campbell went on to suggest that the ward should be much closer to the University to facilitate medical education. Campbell cautioned that any unnecessary duplication of services and costs should be avoided. Dr Rennie (RPAH) then spoke. [Rennie specialised in neurological and psychiatric problems and might have had an interest in the creation of a hospital for psychiatric and nervous disorders close to the University and to RPAH, where he had an honorary appointment.] Rennie reminded the discussants that Sinclair had previously requested that Sydney Hospital and RPAH create inpatient facilities for incipient insanity and that, in the case of RPAH it '... had been allotted but had never (*sic*) occupied'. Referring to the existing facility at Darlinghurst, Rennie expressed that this facility was satisfactory in every respect but its site, an opinion which was supported by Dr Gillies (RPAH). The conjoint meeting proceeded to ratify two resolutions:

That this meeting of representatives of the Sydney, Coast and Royal Prince Alfred Hospitals recognised the necessity for the early treatment of nervous diseases and the early stages of nervous disorders, and is of the opinion that none of the three hospitals mentioned are suitable for that purpose, therefore recommend that steps should be taken to establish a special hospital for this purpose, and with this object urges upon the Minister of Health the advisability of appointing a new subcommittee to consider the whole question and make recommendations.

That such a hospital should be situated as to be readily available to the teaching of medical students in these important subjects.¹⁹

The RPAH Medical Board next met on the 8th of December 1919.²⁰ At this meeting, members were shown a letter from the Undersecretary of the Minister for Public Health rejecting the recommendations related to the establishment of a Department of Psychotherapy. The RPAH Minutes do not state why the Minister rejected the proposal.²⁰ [In the opinion of the present author, Sinclair may, at this time, have wished to avoid the diversion of funds, and other resources, from two other projects. One of these projects was the conversion of the psychiatric rehabilitation facility for returned servicemen at Broughton Hall into a large voluntary hospital for mental disorders. Sinclair might also have had in mind the creation and partial funding of a Chair of Psychiatry at the University of Sydney with associated clinical attachments at RPAH and at Broughton Hall Special Hospital.]

7.11 Further interest at RPAH, after 1919, in the establishment of a voluntary inpatient psychiatric facility

In her book about the history of RPAH, Muriel Knox Doherty, formerly a senior health administrator, commented on attitudes within the medical profession and within the nursing profession concerning psychiatric disorders during the years that followed the Great War:

Although there had been some alleviation of the way in which those with mental illnesses were treated in Australia there was still much to be done. By 1919 there was much opposition to treating patients with mental conditions in general hospitals. There was general agreement, however, that neurasthenia was a result of modern warfare and was directly or indirectly the result of actual concussion or

shell shock, had, as predisposing causes of fear, of being afraid, terrifying experiences, appalling sights, high explosives and lack of sleep. It was believed that the individual suffering from this problem was not insane, or a malingerer, and could be successfully treated.¹²

Coincidental with the opening of the Special Hospital at Broughton Hall in 1921, RPA Hospital received an opportunity to finance a psychiatric facility from a remote source. The Joint Committee of the Red Cross Society and the Order of St John of Great Britain remitted a gift of 15,000 pounds sterling to the Governor-General of Australia, Sir Ronald Munro Ferguson, to be employed as a 'Psychiatric Trust Fund' to support a public and charitable purpose of the Governor-General's choosing. RPAH was destined to become the beneficiary, but it was not possible to proceed with the construction of a psychiatric facility at RPAH before there was a guaranteed source of funding to cover annual staffing and operating costs. The creation of that facility, more than a decade later, will be discussed in the next chapter of this dissertation.

7.12 Broughton Hall Special Hospital

After the last of the returned servicemen at Broughton Hall had been discharged, Sinclair converted the facilities at Broughton Hall into a voluntary hospital of approximately 140 beds for the management of mental disorders. The Broughton Hall Special Hospital opened on the 4th of April 1921. Commenting on this bold initiative, the psychiatrist-historian John Bostock noted that, in 1914, Victoria became the first state within the Commonwealth to allow voluntary psychiatric admissions to mental hospitals and that NSW would remain in an anomalous position concerning voluntary psychiatric admissions for another two decades.

New South Wales, under the direction of Dr Eric Sinclair, Inspector-General of Mental Hospitals, attacked the problem (of voluntary admission) without legal safeguards. His department shortly after the first World War took over the Red Cross Hospital at Broughton Hall [...] From this twist of circumstance a voluntary psychiatric clinic eventuated. In the words of Dr Ernest Jones (The Director-General of Mental Hospitals for Victoria) it was by ‘an admirable and illegal procedure.’²²

7.13 The creation of the Chair of Psychiatry at the University of Sydney and the appointment of Professor Sir John Macpherson

Sinclair was massively influential in the creation of the Chair of Psychiatry at the University of Sydney—the first Chair of Psychiatry in Australasia.²³ Details concerning the creation of the Chair and concerning the appointment of Sir John Macpherson to the Chair are recorded elsewhere.²⁴ Sinclair’s Department of Lunacy provided half of the monies required for the creation and maintenance of the Chair. The Senate decided that the successful applicant would attend to clinical matters rather than to research.²⁴ The Senate stipulated the various clinical responsibilities of the appointee in a document labelled ‘Suggested Conditions of Appointment to the Chair.’²⁵ He would have senior consultancy responsibilities at RPAH and at Broughton Hall Special (Voluntary) Hospital. The same meeting of the Senate authorised a letter to RPAH suggesting that a Department of Psychiatry should be created at that hospital.²⁵ Sinclair was noted to be a member of the selection committee of the University that would choose the successful applicant. Because Sinclair was a Scot and a medical graduate of the University of Glasgow, he would certainly have been aware of Macpherson’s longstanding interest in the management of cases of incipient mental disorder in general hospitals. During his fifty-two months in NSW, Macpherson strengthened the status of

psychiatry as a medical specialty by his many professional activities; by his actions as the Chair of Psychiatry at the University of Sydney; by his role as advisor to the State Government and by his clinical leadership at RPAH and at Broughton Hall Special Hospital. Macpherson's professional activities were followed with much approval by the local media.²³

Within a year of his arrival in Sydney, Macpherson acquired six beds in the medical wards at RPA Hospital for the management of incipient mental diseases. These beds were retained by the Department of Psychiatry until the opening of the Psychiatry and Neurosurgery Pavilion in 1938.²³ In February 1923, the *Daily Telegraph* reported that Macpherson had inaugurated a 'special outpatients clinic' at RPAH, 'the first of its kind to be established within the grounds of a general hospital in Australia.'²⁶ Macpherson is reported as saying that the goals of the special outpatient's clinic were threefold; first, to provide skilled medical advice to persons suffering from the early symptoms of mental and functional nervous diseases and to afford them opportunities for receiving treatment, if possible, before the malady became confirmed; second, to enable education of the medical profession in the essential features of mental diseases, especially at the stage at which they are most often met with in private practice; and thirdly, to enable closer linking of psychiatry with general medicine and the breaking down of the artificial barrier caused by specialism in mental hospitals, at a distance from medical centres and aloof from general hospitals.²⁶

In the Royal Prince Alfred Gazette of July 15, 1937, there is an account of the growth and functioning of the special outpatient's clinic. Referring to the role of Macpherson, this account reads:

For three years, with the help of another able local specialist in the person of Dr Ralph A. Noble, M.B., Ch.M., DPM, as Honorary Assistant Physician, he built up

a clinic, mostly for outpatients, though a few in-patients were also admitted, the total in 1928 having reached 182. This was practically the maximum number that could be treated in the few beds that were available in the medical wards, and the number last year was 177. In the out-patients Department, however, the work of the staff has been greatly developed. In 1928-29 the total number of out-patients was 731, and in 1935-36 this number had risen to 2,231 in almost equal numbers of males and females, who attended in all 6,333 times in the year, which makes about 125 patients in every week. This of course is not one of the largest out-patients clinics but the consideration of the condition of all these people involves a close examination of their circumstances and surroundings, family history, and many other details which may enable the physicians to diagnose their complaints.²¹

During his time in NSW, Macpherson published three papers on clinical and theoretical issues in the *Medical Journal of Australia* and delivered at least eight lectures to medical audiences, including one on the merits of psychiatric outpatient clinics.²⁷ During the decade after the opening of the OPD clinic at RPAH, psychiatric outpatient clinics would be established at most of the major general hospitals in NSW.

7.14 The Royal Commission on Lunacy Law and Administration in NSW (1923)

As an expert witness before the Royal Commission on Lunacy Law and Administration (1923), Macpherson advocated the creation of inpatient and outpatient services at general hospitals throughout NSW.²⁸ He also argued in favour of voluntary admissions to mental hospitals and advocated the least restrictive legislative formalities concerning those admissions.²⁹ The Commission recorded the testimony of other prominent psychiatrists of the

day, including those of Drs Chisholm Ross, Charles Hogg (later to become the third Inspector-General of Mental Hospitals) and Andrew Davidson.

Dr Davidson's testimony is especially pertinent to the history of the development of GHP in NSW.³⁰ Davidson was an experienced psychiatrist who had been the Medical Superintendent at Callan Park for six years. Davidson informed the Commissioners that, when he arrived in Australia from Britain twenty years earlier, he had been 'agreeably surprised' that the mental institutions in NSW were 'much superior' to those in England and Scotland. He informed the Commission that, at Callan Park, two wards had been sequestered for the admission of male voluntary patients and two for female voluntary patients but that the legal status of those patients was anomalous. Davidson strongly supported Sinclair's request that the Commissioners should recommend legislation to validate voluntary admissions to mental hospitals. In support of voluntary admission to general hospitals, Davidson submitted two papers by Dr Montgomery Mosher, who was the Attending Specialist in Mental Diseases at the Albany Hospital in New York.³¹ In 1900 Mosher described the birth of the psychiatric pavilion at the Albany general hospital, but Davidson was also able to provide a paper written by Mosher for oral presentation by Davidson at the ninth session of the Australasian Medical Congress in Sydney in 1911, which described the excellent outcomes of the mental health initiative that had been created at Albany.³² Extracts from Mosher's 1911 text were reproduced in the record of the proceedings of the Commission. A summary of Dr Mosher's text is recorded in *Chapter Six*.

Davidson also gave the Commissioners extracts from a paper that he had read before the University of Sydney Medical Society in 1908.³³ That paper examined mental diseases from a sociological point of view. The commissioners questioned Davidson over the applicability of

Mosher's advice to the context of NSW. Davidson responded that a hospital of about 100 beds, but otherwise resembling the one in Albany NY, should be built near to the existing pavilions at RPAH on a site near the Agricultural School. From the vantage of the present day, it appears that Davidson demonstrated remarkable foresight. The site suggested by Davidson was very close to the one later chosen for the construction of the Psychiatry and Neurosurgery Pavilion at RPAH, which opened in 1938. In response to a question from the Commissioners concerning the future of Broughton Hall Special Hospital following the creation of the proposed facility near RPAH, Davidson opined that Broughton Hall had served an excellent purpose but that it was too far from the University and from a major teaching hospital, and too close to a mental hospital. He suggested that, following the opening of the new facility near the University and RPAH, Broughton Hall might be converted into a private psychiatric hospital.³⁰

The Commission had been created to inquire about the processes by which patients were being admitted, treated and discharged under the provisions of the Lunacy Act of 1898; to identify any defects in those processes and to offer suggestions to the Government for improvements to the conditions that existed in public and private mental hospitals. Among their conclusions, the Commissioners found that there was overcrowding in the public mental hospitals and that the overcrowding was 'detrimental to the interests of the patients.' The Commissioners made several important recommendations: prompt action should be taken to remedy the evil associated with overcrowding by proceeding with the plan to build a new mental hospital at Orange. The laws of NSW should be changed to allow the voluntary admission of certain classes of patients to mental hospitals. Special hospitals should be established, and wards attached to general hospitals for the treatment of 'borderline and early mental cases.' Concerning the processes by which patients in public and private mental

hospitals were then being managed and treated, the Commissioners concluded that their management was humane, scientific and generally acceptable, but that ‘minor acts of roughness or impatience may occasionally occur in the treatment of patients by probationary attendants and nurses, they are very unusual and must be promptly discovered.’³⁴

The Commissioners ended their report with praise for the Inspector-General, who, during the five months of the existence of the Commission, had spent more time providing evidence than any of the other eighty witnesses.³⁵ In his *History of Medical Administration*, Cyril Cummins commented that, whereas the inquiry was extensive and had been useful, its ‘recommendations were disappointing and inconclusive and did not propose any major changes in lunacy legislation ... Overcrowding was admitted (it could not be otherwise ignored).’ The weakness of the findings and the recommendations of the Commission may relate to the fact that the eight Commissioners were all drawn from the Legislative Council and the Legislative Assembly.³⁶ Cummins suggested it was possible that they were reluctant to criticise deficiencies that had resulted from the inertia of the NSW Government of which many of them were a part.

7.15 The end of a phase in the history of GHP in NSW: the death of Dr Eric Sinclair and the retirement of Professor Sir John Macpherson

Sinclair died while travelling to Orange on 20th May 1925. The *Sydney Morning Herald* reported Sinclair’s passing under the heading ‘Great Alienist’ as follows: ‘He had held the position of Inspector-General of the Insane for the past 27 years and by all it is agreed that the State never had a more efficient or more conscientious officer.’³⁷ In the following year Sir John Macpherson sailed from Sydney and into his retirement in England. Macpherson and Sir Harold Dew, the Professor of Surgery at Sydney University, later provided expert advice to

the architect who designed the Psychiatry and Neurosurgery Pavilion, which was destined to open at RPAH in 1938.³⁸ In 1928, two years after his return to Britain, Macpherson was honoured by an invitation to deliver the ninth annual Maudsley Lecture.³⁹ As part of his broad discourse about modern psychiatry, Macpherson praised the situation in NSW: ‘In the same State it has recently been arranged that every large general hospital should make provision for the accommodation and treatment of patients suffering from mental and nervous disorders.’³⁹ Macpherson would have been very disappointed if he had known that three decades would elapse before any large general hospital in NSW, other than RPA Hospital, would contain more than a few beds for psychiatric patients.

7.16 Conclusions

The narrative concerning psychiatry in NSW during the first decades of the twentieth century is dominated by the leadership of the second Inspector-General of Mental Hospitals for NSW, Dr Eric Sinclair. It is evident that Sinclair’s psychiatric philosophy and his psychiatric attitudes were strongly associated with those that prevailed in his birthplace—Scotland. Sinclair had a crucial role in the importation of Sir John Macpherson in 1921 from Scotland to occupy the newly created Chair of Psychiatry at the University of Sydney. Macpherson was a forceful advocate for the entrance of psychiatry into general hospitals, as was the Scottish-born Sydney psychiatrist, Dr Andrew Davidson. It is also relevant to the stated thesis of this dissertation that Davidson cited the successful clinical experiment in the United States, in Albany, New York, to support his argumentation for the entrance of psychiatry into the general hospitals of NSW.

As Inspector-General of Mental Hospitals, Sinclair exercised powers well beyond those of simple advocacy. During twenty-seven years he used those powers effectively to establish a

foothold for psychiatry at RPA Hospital. Unfortunately, Sinclair was not able to prevent the overcrowding in his mental hospitals or to buttress his mental health services against increasing overcrowding and a terrible decline in the quality of care within the mental hospitals of NSW that would occur in the coming decades.

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Chapter Eight

Psychiatry in the doldrums (1925 to 1961)

8.1 Introduction

Chapter Eight examines the fate of the psychiatric services of New South Wales between 1925 and 1961. During those thirty-six years the Government of New South Wales would fail to give adequate support to the mental hospitals, which would consequently become increasingly overcrowded and dysfunctional. There was a small but encouraging development at the Royal Prince Alfred Hospital, where a Psychiatry and Neurosurgery Pavilion was planned to open in 1938. Also in the late 1930s, in an otherwise dismal psychiatric landscape, there was another glimmer of hope with the advent, from Europe, of new treatments for severe mental disorders. When, in the mid 1950s, the Federal Government was forced to awareness of the plight of the mentally ill throughout Australia, it commissioned a review of mental health services throughout the nation.

8.2 Psychiatric services proceed into the doldrums

The narrative concerning psychiatric services in New South Wales between 1925 and 1961 will not be remembered by reference to the names of the various Inspectors-General of Mental Hospitals who led that service during those years. Cyril Cummins, who was eminently equipped by his long professional experience to judge the effectiveness of psychiatric leadership, concluded that no leader of the mental health services of NSW prior to 1961 had such effective authority as Norton Manning or Eric Sinclair. However, it is arguable that no Inspector-General could have saved the psychiatric service of NSW from decline. This is because of deteriorating economic conditions in the 1930s, the dire effects of the Second World War and the neglect by the Government of New South Wales for the care

of patients in its mental hospitals.¹ During those years, all the governments of countries that engaged in military action were distracted from the welfare of their most disadvantaged civilians. In the State of New South Wales, the persons who suffered the most from governmental neglect were probably the patients in the mental hospitals.

Following Sinclair's death, Charles Hogg was appointed as the third Inspector-General of Mental Hospitals. In that year Sir John Macpherson was still the Professor of Psychiatry at the University of Sydney but was at the point of returning to England and into his retirement. Hogg's first Annual Report (1926) began with a plea to the Legislative Assembly for an overhaul of major aspects of the Lunacy Act of 1898. Hogg reminded the Government that both Eric Sinclair and the Master in Lunacy had repeatedly asked that the Act should be updated to permit, and to encourage, the treatment of the earliest manifestations of mental disorder by voluntary admission into psychiatric care. Hogg referred to the draft amendments to the Mental Health Act that were then before the Minister: 'The amendments suggested cannot be too strongly stressed if New South Wales is to maintain its position as a State with up-to-date provisions for the treatment of mental patients'.²

The reader will recall that, under the leadership of Eric Sinclair, the mental health service had been illegally admitting patients voluntarily into its mental hospitals since 1915, and into the Broughton Hall Special Hospital from the date of its opening in April 1921. However, in 1926, the illegality of those admissions remained a concern for the Inspector-General. Hogg asked for legislation to allow three categories of admission and management of psychiatric patients. The first category would contain those who had incipient mental disorders or early, and easily manageable stages of mental disorder; they should be voluntarily admitted to the ordinary wards of a general hospital or to a ward at Broughton Hall Special Hospital. The

second category would contain patients who, although harmless to others, were at risk of hurting themselves or committing suicide. These patients should be detained for care and treatment in a special hospital, such as Broughton Hall Special Hospital. The third category would contain those who were manifestly so mentally disturbed that they required compulsory detention, either for their own protection or for the protection of society. Members of that group would continue to be managed as certified patients in the ordinary mental hospitals.² Later in the same Report, under the heading Establishment of Psychiatric Clinics at General Hospitals, Dr Hogg made this important observation about the role of the general hospitals:

The Department [of Lunacy] has been able to interest the General Hospitals in the question of early treatment of persons suffering from mental disease, and through its efforts, in addition to the Psychiatric [Outpatient's] Clinic at Prince Alfred Hospital now of some years standing, has been able to have established Psychiatric Clinics within the General Hospitals at Newcastle, Goulburn, Parramatta and Orange, the Sydney Hospital and Royal North Shore Hospital. Medical Officers of the Department act as honoraries at Newcastle, Parramatta and Orange, and much improvement in the condition of incipient mental cases should result.

Hogg added that those psychiatric outpatient clinics functioned in accordance with the latest advances in psychiatry. Because they provided expert advice to persons who were in the earliest stages of mental disorder, attendees might overcome their problems and avoid severer forms of mental illness, certification and admission to a mental hospital.² The reader might note that the establishment of the first six psychiatric outpatient clinics at general hospitals in NSW all happened within three years of the creation of Professor Macpherson's 'educative

clinic' for 'early mental cases' at the Royal Prince Alfred Hospital in February of 1923. Hogg added the following comment about his intention to bring cases of mental disorder into the general hospitals:

In this connection the importance of the establishment of definite Psychiatric pavilions (at the larger general hospitals) with beds for early mental cases, together with definite clinical departments for study and research and for the training of students in the early symptoms of mental disease must be stressed.³

Hogg advised that these wards should be attached, where possible, to hospitals that were linked to medical schools. Hogg added that the psychiatric patients who were admitted to general hospitals would gain the 'incalculable' advantage of access to the advice and treatment of specialists in other branches of medicine and surgery.³ Throughout his ten years as Inspector-General of Mental Hospitals, and despite his repeated complaints in his Annual Reports about the worsening conditions in the mental hospitals, Hogg had no success in reducing the overcrowding. In an autobiography which he published in 1968, the Sydney psychiatrist Dr AT Edwards opined that Hogg should not be blamed for the appalling overcrowding.⁴ 'Australian psychiatry owes much to Charlie Hogg than has been recognised.' Edwards excused Hogg's failure to save the mental hospitals:

Hogg had to fight continually against Government parsimony. There are no votes in the mental hospitals! They were yet to receive the unfavourable publicity that they earned after the Second World War, culminating in the Royal Commission of 1961. This made the hospitals of sufficient political importance to enforce action by the Government to loosen the Treasury purse strings.⁴

Edwards praised Hogg for the establishment of psychiatric OPDs in general hospitals throughout the State. In his autobiography, Edwards described a medical profession that he

judged to be indifferent towards psychiatry. According to Edwards, it took more than twenty years for psychiatry to achieve an equal footing with other medical specialties in the general hospitals. As late as 1946 when he was appointed as an honorary psychiatrist at Sydney Hospital, it was rare for other specialists to ask him to perform consultations.⁴

8.3 Professor William Siegfried Dawson

In the preceding chapter there are details concerning Sir John Macpherson's achievements at the University of Sydney, at RPA Hospital and within the psychiatric service of NSW.⁵

During his fifty-two months in New South Wales, Macpherson had successfully introduced ideas about the integration of psychiatry into general medicine and into the general hospitals.⁵

Macpherson was succeeded as the Chair of Psychiatry by Dr William S. Dawson, an Oxford graduate, who had gained postgraduate experience at the Maudsley Hospital and at Johns Hopkins in the USA, where he had studied in the Department led by Adolph Meyer.⁶ Dawson would become internationally known as author of the popular textbook *Aids to Psychiatry*, which ran to eight editions.⁷ Dawson was more sympathetic to Meyerian and to

psychodynamic ideas than Macpherson had been—a fact which will be evident to any reader of his textbook.^{6,8} Dawson is also credited for his contribution to the creation, in 1946, of the

Australasian Association of Psychiatrists. Dawson's career had a few episodes of triumph but was also characterised by many years of stasis and of absence. Dawson surrendered his

Professorship between 1935 and 1937 so that he could attend to his private practice but he

remained at the University as a Lecturer during those years. In 1942, Dawson volunteered for engagement in the Second World War but was repatriated with problems resulting from

filariasis that he had contracted during the First World War and he required treatment at the

Concord Repatriation Hospital.⁶ According to Dawson's obituarist Dr J.D. Russell, 'Though always courteous, he was ever a shy, reserved, sensitive, retiring man. He evinced outwardly

little concern for his public image and indeed had no talent in projecting it.’⁹ An entry in the Australian Dictionary of Biography adds details to the image of Dawson:

Six ft 2 ins (188 cm) tall, with blue-grey eyes and dark hair, Dawson was regarded by his colleagues as shy and retiring. Others found that, in his later years as professor, the bright, dynamic psychiatrist had become cynical and disillusioned with his work.⁶

In 1981 David Maddison wrote, in relation to the Chair of Psychiatry at the University of Sydney: ‘...it was only in 1957 that Australia took the plunge into the establishment of a full-time chair of psychiatry’.¹⁰ This is an intriguing statement because it ignores the fact that John Macpherson, William Dawson and Bill Trethowan had been Maddison’s predecessors in the Chair and that all had initially accepted full appointments. Perhaps Maddison was implying that Dawson did not give his academic appointment his full attention. It seems fair to comment that, during his twenty-four years at the University of Sydney, and despite his other achievements, Dawson failed to make an impact on the psychiatric services of NSW that would match the impact of his predecessor, John Macpherson (1923 to 1926) or of his successor, William Trethowan (1956 to 1962). However, the coincidence of Dawson’s tenure with the most troubled years of the twentieth century should not be ignored.

8.4 Stringency and overcrowding affect the mental hospitals (mid 1920s to the late 1950s)

According to the historian Milton Lewis, for nearly four decades the mental hospitals across Australia went through long periods of overcrowding and of stagnation. There were also periods of physical deterioration and disrepair.¹¹ A major reason for this decline was that governments failed to fund psychiatric services at a rate proportionate to the increasing

admissions and the occupancy of the mental hospitals.¹¹ Lewis explains that whereas NSW Government expenditure on mental asylums actually increased from 1.04% in 1890 to 1.43% of its total expenditure in 1930, as a proportion of Government expenditure on hospitals and charities, mental asylums attracted 39.1% of expenditure in 1890 but only 22.7% in 1930.¹¹ According to Stephen Garton, the proportion of all NSW Government expenditure on hospitals and charities that was limited to mental hospitals declined from 29 per cent in 1920 to 22 percent in 1930.¹²

In his first Annual Report (1926), Dr Hogg made a long and emotive plea for the Government to deal with overcrowding: He reported that his service was responsible for 8,130 inpatients but that there was only permanent accommodation for 7,035 persons. This left a total of 1,095 to be accommodated by temporary means, ‘...which were only provided by the greatest difficulty.’¹³ After providing these alarming statistics, Hogg pleaded with the Government that it had a moral responsibility to provide good accommodation, care and treatment because most of the patients in the mental hospitals had been compelled by the Mental Health Act to accept admission and management. Referring to that moral responsibility Hogg said:

Under present arrangements this is not the case as overcrowding is such as to be detrimental to the treatment the institutions are able to afford, and it imposes unfair burdens on the officers and nursing staff in trying to supply the deficiencies; until satisfactory relief is obtained it is impossible to effect necessary extensive remodelling of some of the old buildings, which are unsuitable now for modern treatment of the mentally afflicted.¹³

8.5 Tantalising prospects in psychiatric treatment

During his decade in charge, Hogg was not able to report any improvements in the occupancy of his mental hospitals, but in his Annual Reports he noted the various advances in psychiatric treatment which were becoming available in the psychiatric service. In 1928, Hogg reported that there were psychiatric OPD clinics at seven major general hospitals and that there were definite plans for an inpatient unit at one major general hospital—the Royal Prince Alfred Hospital. Hogg also noted that therapeutic activities had increased at the Reception Houses in Darlinghurst, Orange, Newcastle and Goulburn and Hogg asserted that there had been many successful therapeutic outcomes.¹⁴ In 1929 Hogg reported that OPD Clinics were functioning at the following hospitals: RPAH, Sydney Hospital, St Vincent's, Lewisham, North Shore, Parramatta, Newcastle, Goulburn and Orange (Orange General Hospital), but Hogg added 'it is regretted that psychopathic wards have not been established at any of the larger General Hospitals.'¹⁵

In 1931 an editorial in the *Medical Journal of Australia* thundered that overcrowding was 'a public scandal' and 'year after year the zeal and earnestness of the chief administrator are apparent, and year after year the ministerial deaf ear is turned to his importunities.'¹⁶ In 1934 Hogg reported that three child guidance clinics would be operating in New South Wales—one of them at the Royal Prince Alfred Hospital under the direction of Professor Dawson.¹⁷ In the same Annual Report, Hogg cited an article in the *American Journal of Psychiatry* (July 1931) in which it was strongly argued that psychopathic wards should be established in general hospitals. In his Annual Report, Hogg advised that psychopathic wards in general hospitals would help to prevent insanity in a large proportion of those who were developing initial symptoms. In psychopathic wards, cases of incipient insanity would benefit from the expert care of the physicians, surgeons and nurses who staffed the general hospitals. Hogg estimated that fifty percent of patients admitted to those wards would be saved from

certification and admission to institutions for the insane. He added that the management of incipient cases of insanity in general hospitals would lead to better clinical instruction for physicians and for medical students. This, in turn, would result in improvement in the ability of the medical profession to recognise incipient cases of insanity, which would bring enormous gains to the citizens of the State of New South Wales.¹⁷ Hogg retired in 1935 and was succeeded by Dr John Wallace, who would retain that appointment for six years.

In 1936, Wallace reported that there were 10,551 patients in his mental hospitals but accommodation for 9,459, resulting in a discrepancy of 1,092 beds.¹⁸ In 1938 Wallace recorded the commencement of treatment programs that utilised Cardiazol therapy and insulin coma therapy at some mental hospitals, the latter treatment requiring additional trained staff. He also noted the opening of the Psychiatry and Neurosurgery Pavilion at the Royal Prince Alfred Hospital.¹⁹ In the financial year ending in 1939 there were 1,103 voluntary admissions and 1,401 certified admissions. In that year there was accommodation for 9,635 persons but there were 11,119 resident patients, an excess of 1,484 patients.²⁰ [This occupancy rate of 116 percent shows a degree of overcrowding that a twenty-first century psychiatrist would consider incredible and outrageous.] In 1939 Wallace reported that 450 patients who had had schizophrenia and some cases who had manic-depressive illness had received Cardiazol treatment and that the results, especially in early cases, had been very favourable.²¹ He added that Cardiazol had been ‘found more suitable generally than Insulin treatment.’²¹ In several of his Annual Reports Wallace claimed better nurse education programs, including a program in general medicine which had been provided at the Prince Henry Hospital (the renamed Coast Hospital) since 1928.

8.6 Concerning psychiatry at the Royal Prince Alfred Hospital: 1921 to 1938

It was noted in *Chapter Seven* that, in 1921, the Joint Committee of the Red Cross Society and the Order of St John of Great Britain had remitted a gift of £15,000 to the Governor-General of Australia, Sir Ronald Munro Ferguson, to be applied towards a public and charitable purpose. It was decided that the Royal Prince Alfred Hospital would become the beneficiary. A mental health facility would be created adjacent to RPAH but that facility would be useless without a guaranteed source of funding to cover recurrent staffing and operating costs. On 15th October 1935, when the foundation stone for the Psychiatry and Neurosurgery Pavilion was laid, the *Sydney Morning Herald* reported:

It was in 1905 that accommodation for curable mental patients at public hospitals was first publicly suggested in New South Wales. In his annual report of that year the late Dr Eric Sinclair, Inspector-General of Mental Hospitals, said that he considered that general hospital treatment of such cases had many advantages a special department could provide.²²

The *Sydney Morning Herald* then referred to Dr Andrew Davidson's efforts, over many years, to encourage the entrance of psychiatry into general hospitals. In 1908 Dr Davidson, who was then the superintendent of Callan Park Mental Hospital, had addressed the Medical Society at the University of Sydney. The *SMH* reported on Davidson's presentation as follows:

The management of the early stages of mental disease is a subject of the greatest public importance. One hopes that Sydney, though it now has a small hospital in a special ward at the reception house, will do still more, and will establish wards with outpatient facilities at the Prince Alfred Hospital, or that a hospital such as is being built in Melbourne should be erected close to the University. This would mean that individual treatment would be given in each case, all histories fully

investigated, causes ascertained, and treatment therefore given on a rational basis. It would be a benefit to the medical student, who would not only be taught by lectures, but would have ample opportunities for examining patients himself and watching daily the effects of treatment.²²

The *SMH* article stated that the Great War had interrupted the introduction of psychiatry into general hospitals but that, during his Presidential Address to the Medical Association in 1925, Dr Davidson had made a plea for the restoration of that priority. The *SMH* continued:

A great amount of insanity and mental deficiency, he said, could be prevented by proper treatment in the early stages of mental disease, to say nothing of the beneficial results that would accrue from an institution which would enable medical students to be taught that it was just as important to study disease of the mind as disease of the body.²²

There are several articles in the Royal Prince Alfred Hospital Gazette for July 15th, 1937 heralding ‘The New Psychiatry Block’ which was scheduled to open in the following year.²³

It is elsewhere documented that Sir John Macpherson and Sir Harold Dew advised the Government Architect regarding the design of the proposed Psychiatry and Neurosurgery Pavilion²⁴ but the 1937 *Gazette* article stated that the Board of Directors of RPAH had accepted the advice of a Special Committee, together with that of the honorary medical staff of the Psychiatry Department, concerning the final details of the new facility and the services that it would provide.²³ According to that Gazette article, there were four psychiatrists in that Department of Psychiatry: Professor WS Dawson and Dr LW Bond, both of whom were Honorary Physicians, and Drs JA McGeorge and CH Swanton both of whom were Honorary Assistants.²³ The Pavilion opened in 1938. The RPA Directors were proud that:

Royal Prince Alfred Hospital is not only the first hospital in Australasia to provide special in-patient accommodation for acute mental cases but is the only general hospital in the Empire which has a specially designed building for such cases in its grounds.²³

This claim might have bypassed the fact that, since 1908, there had been a purpose-built psychiatry annex adjacent to the Perth Hospital in Western Australia. The claim on behalf of RPAH might have been justified by the fact that the facility in Perth was of a less sophisticated design and was intended to function more as a reception ward for the Department of Lunacy of Western Australia than as a ward for the management of cases of non-psychotic mental disorder or incipient mental disorder.^{25,26} The new pavilion at RPAH was constructed of red fireproof brick and had three stories. The top floor housed the neurosurgery facilities for RPAH. The building was T-shaped with the long axis of the T pointing towards the west. There were nursing observation posts at the two lower (psychiatry) levels near the junction of the axes of the T, close to a lift that connected the three levels. There were many fire escapes. On the ground floor on the northern side of a corridor were: Professor Dawson's office, the laboratory, teaching and clinical examination rooms. The southern side housed the kitchen, two warm (therapeutic) baths with continuous water at 100 Degrees Fahrenheit, three rooms with armoured glass windows for 'restless patients' and two single bedrooms.²⁷ On the second level there were four psychiatry wards, each for the accommodation of four to six patients. Long verandahs on both levels of the long axis bathed in sunlight from the north. There was wire netting to prevent patients from jumping from the verandahs. The Pavilion was 'away from the activities of the traffic, and activities on the University oval will doubtless prove of interest to the patients.' All the windows had restricted opening and some doors were locked on one side to ensure security.²⁷



The Psychiatry and Neurosurgery Pavilion at the Royal Prince Alfred Hospital, viewed from St John's College Oval. Royal Prince Alfred Hospital Annual Report. 1938. Page 19. Courtesy: Museum and Archives, Royal Prince Alfred Hospital.

The in-house journal *R.P.A.* for June 1938 described the formal opening of the Pavilion and informed that the donation of 15,000 pounds by the Red Cross in 1920 (*sic*) had accrued significant compound interest.²⁸ The Hospitals Commission of New South Wales, which had been created in 1929, had ‘... made available the sum of 4,200 pounds for equipment and undertook to provide extra subsidy for the maintenance of patients.’ At the opening ceremony, the Minister for Health of NSW, Mr HP FitzSimons, told his audience that there were 11,000 patients in the mental hospitals of New South Wales, which was costing the State 600,000 pounds per annum and that any step that improved those numbers would greatly benefit the public purse.²⁸



The Psychiatry and Neurosurgery Pavilion, Royal Prince Alfred Hospital viewed from the south. Royal Prince Alfred Hospital Annual Report. 1938. Page 19. Courtesy: Museum and Archives, Royal Prince Alfred Hospital.

8.7 Increasing overcrowding and decline in conditions in the mental hospitals: 1938 to 1955

In 1938, when the Psychiatry and Neurosurgery Pavilion opened for service at RPAH, Dr Wallace recorded the existence of two licensed private psychiatric hospitals in NSW—the one at Tempe and the other, which was limited to female patients, at Mount St Margaret.²⁹ In March 1939 the following editorial appeared in the *Medical Journal of Australia*:

Nearly four years ago we were constrained to make violent protest in these pages about the shameful neglect by government authorities in New South Wales of the mental hospitals department. In none of the other States of the Commonwealth has the head of the mental hospitals department found it necessary to issue such a

strongly worded report as that issued by Dr Hogg in 1934. Never, we are certain, was a report from the medical head of a government department been more justified in fact.³⁰

The editorial went on to note that permanent accommodation was provided in the institutions of the Department of Lunacy for 9,636 persons but that 10,961 were registered, resulting in an excess of 1,325 patients.³⁰ The Editor noted that the mental hospitals of New South Wales have been overcrowded for more than twenty years and very little had been done to change that situation. The *MJA* Editorial commented on Government promises to remedy these terrible deficiencies: "The sum of money promised by the Government will be little more than a drop in the ocean of mental hospital antiquity."³⁰

It seems that the NSW Government ignored the 1939 *MJA* editorial, as it had ignored earlier editorials. The years of the Second World War may have been the worst years ever experienced by patients in the mental hospitals of New South Wales; they must have suffered terribly. In 1940 Wallace reported that most of his mental hospitals had asked to be supplied with electroconvulsive (ECT) machines.³¹ He also reported on the efficacy of Cardiazol convulsive treatment and insulin coma treatment programs.³¹

Dr Wallace retired in July 1941 and Dr E Sydney Morris became Inspector-General of the (renamed) Mental Hygiene Department. Morris, of course, reiterated reports about overcrowding. In 1941, the NSW Government moved all the patients at Kenmore Hospital to the other mental hospitals for the duration of the war so that Kenmore could be used as a military hospital. The overcrowding and toxic conditions that would have resulted in the other mental hospitals beggars imagination. [The present author was unable to locate the Reports for 1942, 1943 and 1944 at the NSW State Library. It seems that those Reports were

casualties of the War years.] An Editorial in the *MJA* in 1943 commented on the absence of Annual Reports for 1941 and 1942 and noted that psychiatry services were then being administered by the Director-General of Public Health.³² The editorial noted that Dr Morris had no previous experience in psychiatry. The same editorial stated:

At the close of the twelve months under review the number of patients, including voluntary patients and inebriates, resident in State mental hospitals was 11,347; permanent accommodation existed only for 9,850, so that the number of excess patients recorded was 1,497. This is the greatest number of excess patients recorded during the last twenty years. ... It might be supposed that the medical and other officers of the department had become used to such an overcrowded state, but if successive reports of inspectors-general are any criterion this is not so. And no one can really believe that the best work can be done for patients in such conditions.³²

The same editorial recorded that one of the mental hospitals [Kenmore Hospital], had been temporarily closed because of the War. The Editor acknowledged that resources were bound to be diverted by the war effort but insisted:

Every right-minded person, whether he is a medical practitioner or not, will back him [Dr Morris], in any effort he makes to protect and to treat and to better the lot of the one group of persons in the community who are least able to help themselves.³²

In 1945 Morris recorded that more psychiatric OPD clinics were operating at general hospitals and that most of the mental hospitals now possessed ECT machines.³³ There was a great shortfall in nursing staff. There were now 10,954 patients in the mental hospitals of

NSW but accommodation for only 9,055—an excess of 1,970 patients and an occupancy of close to one hundred and twenty percent.³³ The effect of this degree of overcrowding on the morale of the patients, on the families of patients and the clinical staff who managed those patients would have been devastating.

Dr Donald Fraser succeeded Morris to become the head of the psychiatric services of NSW between 1950 and 1961. When the Government introduced changes in the administration of health services, Fraser's position as Inspector-General was formally abolished and he became the of Director of Psychiatric Services for New South Wales. In his Annual Reports, Fraser suggested that that the circumstances of the patients in the mental hospitals were improving. However, until the late 1950s the occupancy of the mental hospitals would remain close to one hundred and twenty percent, the number and the training of medical staff would remain inadequate and it would have been almost impossible to conduct psychosocial therapies in the grossly overcrowded wards. Fraser noted that senile patients were being transferred from other mental hospitals to Rydalmere Hospital where they were offered more appropriate management programs. Additional wards were being constructed within the grounds of mental hospitals, but never quickly enough to prevent overcrowding. In several Annual Reports, Fraser predicted that the introduction of new biological treatments would lead to major improvements in his mental hospitals. These treatments and their relevance to the development of general hospital psychiatry will be described and discussed in the next chapter. In 1953 an amendment to the Mental Health Act sanctioned and regulated the performance of psychosurgery in the mental health system and established the legal basis for a Leucotomy Consultative Committee. In 1954 construction commenced on a building that would house the Cerebral Surgery and Research Unit at Callan Park Hospital. This construction would be completed in 1958.³⁴

8.8 The Stoller and Arscott Report on Mental Health Facilities and the Needs of Australia (1955)

The most expert and possibly the most objective evaluation of the mental health services of New South Wales in the 1950s can be found in the Stoller & Arscott Report to the Federal Government (1955).³⁵ The Federal Department of Health had been established in 1921 but, before the Second World War, the Federal Government had very limited responsibility for psychiatric services in the various states of Australia. The Chifley Labor Government (1945 to 1949) gave financial assistance to the States if they would abolish charges to the families of patients who were resident in the mental hospitals.³⁶ In 1954 Sir Earle Page, the Minister for Health in the Menzies Federal Government commissioned a review of psychiatric services across Australia. This was conducted by Dr Alan Stoller, a senior psychiatrist from the Repatriation Department in Victoria, assisted by a public servant, Mr W Arscott.

The Report noted that there had been some improvements in the standard of care within the psychiatric services of the UK, the USA and Canada since 1945, particularly in the two North American countries, ‘...in terms of beds, staffing, extramural activity and research ... Australian standards are generally lower than those existing in the United Kingdom, United States of America and Canada.’³⁷ The Report described psychiatric services in each of the states and territories. It was especially critical of the services provided by the State Government of New South Wales.

The Mental Hygiene Department in New South Wales has lagged behind world developments in psychiatry. It has been starved of essential moneys even for adequate maintenance, over so many years, that its outlook has become somewhat restricted. Attempts have periodically been made to raise standards, but these

have invariably failed, because of the lack of introduction of personnel training programs.³⁸

[and]

Facilities in the teaching hospitals were surprisingly poor, and this was reflected in the standard of psychiatry taught to undergraduate medical students.³⁸

The Report noted that the New South Wales Department of Hygiene only supported one adult outpatient clinic per week at each of three hospitals: Broughton Hall Special Hospital, Orange Base Hospital and Parramatta General Hospital.³⁹ The Report recommended that each of the metropolitan mental hospitals in NSW should continue to take acute admissions and to provide care for long-term cases of mental illness, but that each mental hospital should have an active outpatient service for a specified community, which should be located either within that hospital, or in a general hospital that was linked to it. Each mental hospital in NSW should acquire an in-patient service in a local general hospital and all mental hospitals should become more closely linked with the communities from which they were receiving admissions. The Report predicted that, to reduce overcrowding and to meet the needs of an expanding population, New South Wales would need to construct two additional 1,000 bed mental hospitals within the next ten years. The Report acknowledged that those predicted bed numbers might prove to be an over-estimate but that the enormous cost of two new mental hospitals might be significantly reduced by the enhancement of the psychiatric services in the general hospitals and in related communities. 'Whilst this may, for a while, increase general hospital and outpatient costs, the eventual savings could be considerable.'³⁸ The Report noted that there was only one new mental hospital on the drawing board. [This would have been the mental hospital that would soon be created at North Ryde.] Stoller & Arscott predicted that, based on a need for 4 psychiatric beds per 1,000 population and a projected estimate of a

population of 4.2 million, New South Wales would, by 1965-1970 need 16,868 mental hospital beds.³⁸ [The present author notes that it would actually transpire that the number of beds available for 'public' psychiatric patients in New South Wales in 1970 would diminish by forty-four percent to 9,430 beds, which meant that there would be 2.24 psychiatric beds per 1,000 population.⁴¹] If, in 1955, Stoller & Arscott had known the extent of the reduction in psychiatric beds in New South Wales by 1970, they would probably have been astounded. An explanation for the amazing reduction in the need for psychiatric beds between 1955 and 1970 will be provided in *Chapter Nine. The impact of new treatments on psychiatric services* and in *Chapter Ten. A renaissance in psychiatry in New South Wales (1961 to 1994)*. The Report concluded with recommendations for major changes in every aspect of psychiatric services in New South Wales. Psychiatric training programs and psychiatric research facilities should be enhanced by the creation of a post-graduate psychiatric training institute. Psychiatric postgraduate teaching and research concerning the management of neuroses should be linked to clinical activities at Broughton Hall Special Hospital. Research and training concerning acute cases of psychosis should be linked to the Darlinghurst Reception House. Research and training concerning long-term cases of psychosis should be linked to Callan Park Hospital, where better laboratory and diagnostic facilities should be established. Research programs should be elevated to the academic level of non-psychiatric medical research that already existed throughout NSW. Professional recruitment and training should be encouraged for nurses, psychologists, occupational therapists and social workers. Mental deficiency accommodation should be enhanced, and the staff who managed mentally deficient patients should be better trained. The Director of the Mental Hygiene Department for NSW should have greater control of, and be given more direct responsibility for, the services that he was directing. Concerning the accommodation and care of the elderly, the Report noted that 'senile cases' were 'handled by herding old people together in appalling

circumstances' and 'Much of this problem could be taken up by the extension of other old-people's homes.'⁴² The Report also made important comments about existing psychiatric services in general hospitals throughout the breadth of Australia, under a heading of 'General Hospital Psychiatry':

The provision of in-patient beds in general hospitals is, again, largely a post-war phenomenon, even though numbers, outside of Repatriation hospitals, are woefully inadequate. The number of general hospital beds (excluding 'Repatriation') was 37 in New South Wales, 38 in Victoria, around 100 in Queensland, eleven in Tasmania and none in South Australia or Western Australia.⁴³

Adult out-patient clinics existed in general hospitals in all States, but there were only two OPD clinics in Australia that were functioning for seven days per week and both were within the Repatriation service. The Repatriation Department outpatient services in the Grace Building in Sydney were functioning for 40 sessions per week. There were ten OPD clinics in the general hospitals in NSW, including one at the Northcott Neurological Clinic. In 1955, no general hospital in Australia provided well-designed facilities for a psychiatric outpatient service. All the psychiatric outpatient services that existed were shared with other specialties and were often handling far too many patients per session.⁴²

The Stoller & Arscott Report noted that, excluding the 110 beds at the Federal Government-funded Concord Repatriation Hospital, there were less than 40 beds for psychiatric patients in general hospitals in New South Wales.⁴⁴ Two were at the Rachel Forster Hospital, one at the Royal North Shore Hospital and one or two occasional beds at the Lewisham Hospital. At RPAH there were 34 beds (22 male 12 female).⁴⁴

Concerning the Pavilion at RPAH, the Report recorded that the wards at RPAH were ‘... by no means ideal in design’.⁴⁴ There was very little space for ambulant activity, whether indoors or outdoors, as if the wards had been designed for the management of patients who would spend most of their time in bed. A few rooms designed for other purposes had since been co-opted for patient activities. There was a small makeshift dining-sitting room and an occupational therapy area that comprised one room and a verandah. The Report also noted that:

- up to 50% (of the inpatients) were ‘psychotics’.
- the turnover of admissions was 367 per year.
- the average length of stay was just over one month.
- thirty beds were controlled by two senior psychiatrists and four beds by two assistant psychiatrists.
- there was a full-time social worker but no clinical psychologist.
- there were eleven nurses and one wardman on in the daytime, plus a sister-in-charge and a sister for the insulin clinic.
- the nurse: patient ratio was therefore 1:2.4.
- the insulin clinic could manage up to three patients in full coma and four in sub-coma.
- between ten and twenty ECTs were administered daily; and
- very little individual psychotherapy was provided.⁴⁴

The Report does not mention the two continuous warm baths that were considered a therapeutic necessity when the ward was commissioned in 1938. Regarding outpatient services at RPAH, the Report noted that the four psychiatrists and two clinical assistants each conducted one OPD clinic per week, and that 312 new cases were seen yearly, for a total of

1,485 attendances.⁴⁴ The Report quoted the Medical Superintendent of RPAH ‘... that the standard of treatment would be improved with a functioning Professor of Psychiatry.’⁴⁴ Professor Dawson had retired to England in 1951. There is very little in the Report that suggests that Dr Alan Stoller was favourably impressed by the design of the Pavilion or by the psychiatric services that it provided.

It is hardly surprising that Donald Fraser reacted angrily to the findings of Stoller & Arscott.⁴⁵ ‘In my opinion the most unwarranted criticism of the administration by Dr Stoller is that ‘the Mental Hygiene Department of New South Wales has lagged behind world developments in psychiatry’.⁴⁵ Fraser did not respond in detail to the numerous specific criticisms that had been listed in Stoller & Arscott’s Report. Instead, he commented about the introduction of the new ‘tranquillising’ drugs, chlorpromazine and reserpine:

These two drugs have been found to be extremely useful in the treatment of some chronically disturbed patients, and at Parramatta in particular, some very good results have been achieved. The drugs themselves are expensive but it is proposed to extend their use within the hospitals as the results so far obtained have much more than justified their expense.⁴⁵

Fraser also noted that insulin coma treatment had been employed at Gladesville Hospital since 1938. He claimed that ECT, Cardiazol shock treatment and occupational therapy were greatly benefiting the patients in his mental hospitals.⁴⁵ In the following year, Fraser’s Annual Report celebrated the arrival of Professor Trethowan to the University and as an adviser of his mental health service.⁴⁶ Fraser predicted that Trethowan’s presence would bolster the recruitment and lead to improvements in the training of medical officers in psychiatry. Then, under the heading “‘Tranquillising” drugs’, including: ‘chlorpromazine reserpine, etc’ Fraser wrote seven paragraphs about the reported benefits to individual

patients following the administration of those drugs, especially the improvements in those patients who were chronically ill. He reported that there were ‘... revolutionary change(s) in the chronic and refractory wards where they have been used.’⁴⁶

8.9 Repatriation mental health facilities and services in New South Wales

The Commonwealth Department of Health had been created in 1921 but its existence would only slowly, and in steps, have an impact on clinical psychiatry in New South Wales. When the Concord General Hospital opened in 1941, its psychiatric services were far better equipped, staffed and managed than any of the psychiatric services provided by the NSW State Government.⁴⁷ There were 110 psychiatric beds in four wards. One of those wards managed severely psychotic patients, but patients who were less psychotic were scattered throughout the other three wards. There was a medical officer allocated to each ward, assisted by sessional consultant psychiatrists. The Stoller & Arscott Report judged that nursing staff numbers were also very satisfactory. The psychiatric service at Concord included two clinical psychologists, two part-time social workers and an educational officer. The turnover of patients was about a thousand per annum. The Report only offered one criticism of the service: that the space for daytime patient activities was inadequate.⁴⁷ Psychiatric outpatient services were offered to persons who were entitled to the support of the Repatriation Department at the Grace Building in the CBD of Sydney where seven psychiatrists attended on a sessional basis. The throughput of outpatients was about 7,000 per annum.⁴⁷ Across Australia, the Repatriation Department was serving a population of about 1,300,000 persons, which was a significant proportion of a population of less than nine million.⁴⁸ The Report noted that ten percent of all the general hospital beds provided by the Repatriation Department were sequestered for psychiatric inpatients.⁴⁸ The Repatriation Department also supported and funded the care of about 1,000 patients in the mental hospitals of the various

States of Australia. The Stoller & Arscott Report concluded that the psychiatric services that were provided at the out-patient clinics, and in the beds in the general hospitals that were operated by the Repatriation Department were superior to those offered by the various state governments.⁴⁸

8.10 The private practice of psychiatry in New South Wales (1955)

Concerning private practice in NSW, the Stoller & Arscott Report noted that, in 1955, there were sixteen psychiatrists in full-time practice in that state. Each saw between 500 and 1,000 patients per annum, of whom between 20 to 40 percent might have been suffering from psychotic illnesses and of whom 10 percent were children.⁴⁹ There were about 200 psychiatric beds distributed through 12 private psychiatric hospitals in NSW, many of which were occupied by ‘mental defectives.’ The Mount St Margaret Licensed Hospital had 150 beds for female patients, nearly half of whom were certified and half of whom had been admitted voluntarily.⁴⁹ According to Stoller & Arscott, ‘Private psychiatry in NSW was poorly developed and did not play the substantial part in psychiatric care that it could in the medical life of the community.’³⁸

8.11 The appalling state of the mental hospitals in NSW in the mid to late 1950s

In his autobiography, a retired Australian psychiatrist, Dr Bill Grant, attested to the dismal conditions within the mental hospitals in the 1950s. Dr Grant entered the state psychiatric service of NSW in 1956 as a medical officer at Callan Park Mental Hospital. He recorded that there were eight medical staff at Callan Park, two of whom were the Medical Superintendent and the Deputy Superintendent. Five medical officers were, like himself, training in the part-time Diploma of Psychological Medicine (DPM) course at the University of Sydney.⁵⁰ According to Grant, there were between 400 and 500 nursing staff working 12-hour shifts.

According to Grant, many patients had syphilitic General Paralysis of the Insane (GPI), but Grant did not estimate their numbers. Pyrotherapy by the introduction of malaria into the bloodstream of patients was still employed in the treatment of GPI. Electroconvulsive Therapy (ECT) and Insulin Sub-Coma Therapy were routinely employed at Callan Park Hospital.⁵⁰ When Grant commenced his duties, Callan Park housed more than 1800 patients, half of whom were ‘in virtually permanent residence’ and 500 of whom were his clinical responsibility.⁴⁸ On night rounds Grant had to step over patients on mattresses scattered through the overcrowded wards. Grant’s account of the situation at Callan Park is consistent with, if less colourful than the account given by Professor Trethowan in an interview that he gave towards the end of his career.⁵¹ In contrast to his disheartening experience at Callan Park, Bill Grant was inspired by the teaching of three psychiatrists in the Department of Psychiatry at the University of Sydney: Professor Bill Trethowan, Dr David Maddison and Dr John Ellard. Bill Grant had a long career in the psychiatric service of NSW with an interlude in private practice during the 1960s.

8.12 Professor Bill Trethowan (1956-62)

Dr William (Bill) Trethowan arrived in 1956 from the University of Manchester, where he had been a senior lecturer, to become the third occupant of the Chair of Psychiatry at the University of Sydney. That Chair, which had been vacant for five years, was still the only chair of psychiatry in Australasia. Trethowan quickly attracted the attention and the praise of the local media. He was an energetic, persuasive and charismatic leader who was able to catalyse many changes in the way that psychiatry was practiced in NSW.⁵² Part of Trethowan’s salary was paid by the State Government in return for his ongoing consultancy concerning all matters relating to mental health in NSW. Dr John Ellard, who lectured in Trethowan’s Department at the University, later described him as ‘... the right man at the

right time, if ever there was one.’⁵² Trethowan contributed to a series of reports and to proposals by expert committees to the NSW Government concerning the mental health services. Cyril Cummins wrote:

Professor Trethowan’s proposals were concerned with updating and rewriting the [NSW Mental Health] Act in consonance with principles of community psychiatry. The Minister accepted Professor Trethowan’s version, and his report was the basic document on which the Mental Health Act of 1958 was modelled.⁵³

Trethowan advised the NSW Government that that voluntary status should be encouraged as the most common mode of admission for psychiatric assessment and management; that compulsory admission should be limited to the most difficult patients and that doctors should be the arbiters of the admission and detention of patients. The proposal that psychiatrists should have almost total control over admission and detention was judged by the NSW Government to be too radical but psychiatrists were generally allowed more agency by the new Act. The Act was framed according to the proposition that, administratively and legally, there was little difference between physical and mental illness. Most of Trethowan’s suggestions were incorporated in the 1958 Mental Health Act despite some pushback from medical, legal and political sources. That resistance was usually based on concerns about the potential for the abuse of civil liberties by medical practitioners.⁵² The 1958 Act made it clear that psychiatric services were to be shifted towards inpatient and outpatient facilities at general hospitals and that those general hospitals should accept responsibility for their nearby communities. The Act provided an equivalent legal basis for involuntary detention in mental hospitals and in wards that were ‘gazetted’ for involuntary detention in general hospitals.⁵³ Trethowan attracted two outstanding local psychiatrists as lecturers in his Department: Drs David Maddison and John Ellard. In 1962 Trethowan returned to Britain to accept the Chair

of Psychiatry in Birmingham. He went on to a brilliant career as an academic psychiatrist and as one of the leaders of the British psychiatric profession. In 1980 Trethowan was awarded a knighthood for his services to British psychiatry and to psychiatric education. Unlike his predecessor in the Chair of Psychiatry, Bill Trethowan was a forceful psychiatric leader whose interventions affected almost every aspect of psychiatry in New South Wales. However, he seems not to have made any major changes in the psychiatric service at RPA Hospital. It seems that, rather than focussing his energies on clinical programs at RPA Hospital, or on psychiatric research, Trethowan directed them towards the introduction of fundamental changes in the psychiatric services of New South Wales and the elevation of standards of psychiatric care throughout that state.

8.13 Conclusions

During the years between 1925 and 1961, the mental hospitals of New South Wales became grossly overcrowded and morale within them plummeted. There is abundant evidence that, for most of those thirty-six years, the Government of New South Wales neglected its responsibilities and failed to provide adequate resources for its mental health services. The NSW Government cannot be excused for neglecting those responsibilities, but any critic must acknowledge that those were years of great social and economic turbulence. During the years between 1925 and 1956 there was a noteworthy absence of forceful and inspiring leadership of psychiatry in NSW, but, whether the presence of a stronger leader in the Department of Mental Health or in the Department of Psychiatry at the University of Sydney, would have altered this sad situation is unknowable.

Away from the mental hospitals there were several encouraging signs for the future of psychiatry. Between 1925 and 1930, outpatient psychiatric clinics appeared at most of the

major general hospitals in New South Wales. Powerful, but sometimes frightening new biological treatments that had been invented in Europe reached NSW during the 1930s and the 1940s. These 'physical' or 'biological' therapies, which included cardiazol shock treatment, insulin coma treatment and electroconvulsive therapy (ECT), were all steadily introduced into the mental hospitals and into the psychiatric wards at RPA Hospital and Concord Repatriation Hospital. Their administration certainly helped some patients but could only slowly begin to impact on the dreadful conditions in the mental hospitals. The relevance of those new 'biological' treatments, and the relevance of the arrival of the antipsychotic drug, chlorpromazine in the mid 1950s, will be discussed in *Chapter Nine: The impact of new treatments on psychiatric services*.

In 1955, the Stoller & Arscott Report highlighted major deficiencies in the psychiatric services of NSW and the urgent need to fill the vacant Chair of Psychiatry at the University of Sydney. The arrival of Professor Bill Trethowan within a year of the advent of chlorpromazine in 1955, followed by the passage of a radically new Mental Health Act in 1958 gave reason to hope for revolutionary changes in psychiatric services in New South Wales. A scandal at Callan Park Hospital was about to lead to a Royal Commission into the management of that institution. In 1961 the McClemens Royal Commission would, in turn, focus public attention on the abysmal conditions in the mental hospitals and would precipitate a radical restructuring of psychiatric services in New South Wales.

Between 1925 and 1961, Australia resembled Britain in its psychiatric institutions, in its psychiatric practices and in its laws concerning psychiatry. During those years the influence of British psychiatry and of British-trained psychiatrists on the psychiatric services of NSW was immense. Between 1926 and 1951 the Chair of Psychiatry at the University of Sydney

was occupied by William Dawson, and between 1956 and 1962 by Bill Trethowan, both of whom returned to England when they had completed their academic appointments in New South Wales. In an article titled 'Letter to America' that was published in the *American Journal of Psychiatry* in 1955, Dawson described Australia as a country that differed from Britain in its geography, in its demography and in some aspects of its social life, but '... we remain a fairly homogeneous society with strong British traditions'.⁵² In that article Dawson mentioned the importance of the British Medical Association in organizing twice-yearly post-graduate lectures.⁵⁴ However, the influence of ideas from the USA was beginning to be felt, and it should be noted that Professors Dawson and Trethowan had both received some post-graduate training in the United States—Dawson at the Johns Hopkins Hospital and Trethowan at the Massachusetts General Hospital.

During these thirty-six years, psychiatrists in New South Wales were becoming increasingly aware of developments in psychiatry in the USA such as the ascendance of psychoanalytic ideas and the creation of psychopathic wards in some general hospitals. They might be excited and sometimes tempted by American psychiatric ideas and experiments, but their professional attitudes and practices were based on British foundations.

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Chapter Nine

The advent of new biological treatments, including drugs, and their impact on psychiatric services in NSW

9.1 Introduction

At the end of the nineteenth century, it was hard for anyone to ignore the fact that, throughout the world, mental hospitals were overcrowded and dysfunctional. Psychiatrists still paid lip service to ‘moral treatment’ but, even in well managed asylums, there was no empirical evidence that moral treatment was more effective than natural healing processes. Nearly all the world’s mental hospitals were overcrowded and staff and patients within them were demoralised. Nor was there empirical evidence that any of the available psychological or medical treatments were having a measurable impact on serious cases of mental illness. This chapter describes the invention of new biological treatments between 1930 and 1961, including pharmacological agents, and then describes their introduction into NSW. These agents would make it possible to control episodes of psychosis and to transform the course of mental illnesses. These treatments could be effectively employed in mental hospitals, in general hospitals, and in office practice. The implications of their availability, for the future of psychiatric services, were profound.

9.2 Psychiatric services in need of effective treatments

According to the historian Edward Shorter, psychiatry at the fin de siècle ‘had reached a dead end:

Its practitioners were concentrated for the most part in asylums, and asylums had become warehouses in which any hope of therapy was illusory. Psychiatrists

themselves had a rather poor reputation among their colleagues as the dull and second-rate, just a step, if that, above the spa-doctors and the homeopaths.¹

In the first half of the twentieth century, the governments of many global jurisdictions, including NSW, shied away from the financial expenditure needed to raise the physical environment and the staffing of the mental hospitals to levels that were at all satisfactory. Those governments paid more attention to escalating political and economic problems than to the plight of the mentally ill in the publicly funded mental hospitals, for which they bore sole responsibility.

In the early decades of the 20th century, Freudian ideas spread throughout Europe and the USA and jostled with proposals about biological treatments—including drug treatments—as possible answers to the blight of insanity. During and after the Great War there was also enthusiasm for behavioural and psychological therapies which had been invented to manage cases of ‘shell shock.’ Nevertheless, it soon became clear that, whatever the effectiveness of those treatments in other settings, the new psychological and behavioural therapies were not effective agents against certifiable insanity, and that their utility in the mental hospitals might be ameliorative but not measurably or significantly. In most nations there was little prospect that general physicians would allow overt cases of insanity to be admitted into their general hospitals. Patients who exhibited behavioural manifestations of mania, paranoia or suicidal melancholia were not tolerated in the wards that were overseen by general physicians and surgeons. Moreover, psychological and psychosocial therapies were not feasible in the limited space between the beds of those wards. Generous ambulatory spaces, both indoors and outdoors, were prerequisites for any psychosocial treatment measures. Another major obstacle to the admission of cases of insanity to general hospitals was that patients who had

florid mental illnesses usually needed hospitalisation for a minimum of six weeks and often for very much longer. Patients who had surgical or acute medical illnesses could usually be treated and discharged from general hospitals in shorter times and with much less difficulty.

9.3 Biological treatments, including drug treatments, that were employed in mental hospitals in the late nineteenth century

In 1881, in his inaugural address as President of the British Medico-Psychological Association, Dr Daniel Hack Tuke made this telling observation:

It must be frankly granted that Psychological Medicine can boast, as yet, of no specifics, nor is it likely, perhaps, that such a boast will ever be made. It may be difficult to suppress the hope, but we cannot entertain the expectation, that some future Sydenham will discover an anti-psychosis which will safely and speedily cut short an attack of mania or melancholia as bark an attack of ague.²

The gravity of this pronouncement was supported by Tuke's immense authority on questions concerning the management of insanity. Tuke was, at that time co-author, with John Bicknell, of the *Manual of Psychological Medicine* and co-editor of the *Journal of Mental Science* and would become the editor of the *Dictionary of Medical Psychology* (1892).^{3,4} Many medical authorities of the time believed that opiates could be used to reduce the symptoms of melancholia, but they did not dispute Tuke's assertion that the available drugs did not correct the root causes of severe mental illness. They recognised that transient symptomatic relief of symptoms was fundamentally different to the cure of illness. They employed certain drugs to modify and to reduce mental and behavioural disturbances in mentally ill patients. Some of those drugs might briefly modify hyperactivity and oppositional behaviours but their quieting effects were limited and were usually short-lived. The drugs in common use were opiates,

bromides, chloral hydrate and paraldehyde. Those agents caused tiredness, drowsiness and, in larger doses, confusion. Moderate to high doses of opiates caused respiratory depression and were associated with a significant risk of causing pneumonia, coma and death. Conscientious alienists worried about the addictive potential of many of those agents—especially the addictive potential of the opiates. The other ‘therapeutics’ of those decades, which included aperients, emetics and bloodletting, were part of Galenic medical practice and were employed to restore the balance of the humours whether the ailment was thought to be of bodily or mental origin.

Early in the twentieth century, hyoscine hydrobromide came into use in many mental hospitals and was often administered to hyperactive patients. However, its efficacy as a sedative was probably no greater than that of earlier drugs. Barbiturates also came into use as sedative agents in the early 1900s. One of the first of the barbiturate sedatives, phenobarbital, was marketed globally in 1912 for its more prolonged sedative effects and would later prove to be a useful agent for epileptic convulsions. However, Tuke’s dictum, in 1881, that there was no ‘*specific*’ treatment or sedative in existence that could be used to significantly control or to cure psychotic processes would prove true until the mid 1930s.

9.4 Syphilis, general paralysis of the insane, and the invention of Salvarsan

In the late decades of the nineteenth century, general paralysis of the insane (GPI) was responsible for significant numbers of inpatients in the world’s mental hospitals. In his Annual Reports for 1893 and 1896 Manning commented on increases in the number of inpatients who had GPI within his service.^{5,6} GPI was a form of presenile dementia that was relatively easily recognised by nineteenth century physicians. It was a late manifestation of the damage caused by syphilis as the disease progressed through the nervous system. An

effective test for syphilis capable of detecting the disease in an early phase of its development would not come about until 1906. Arsphenamine (also known by its trade name Salvarsan or '606') was the world's first modern antimicrobial. Invented in the laboratory of Paul Ehrlich in 1910, it soon became available in Germany for the treatment of *Treponema pallidum*, the bacterium that causes syphilis. Shortly after its introduction in Germany, Salvarsan became available throughout the world's industrialised countries. A truly effective and safe treatment for syphilitic infection would not emerge until 1943 in the form of penicillin.

In 1924, Eric Sinclair reported that, of 8,145 patients in NSW mental hospitals, 86 were identified as having venereal disease as a cause of their insanity.⁷ It is not stated whether these were all cases of GPI. In 1935, it was reported that there were 54 cases of GPI—46 male and 8 female among the 1,397 first admissions to the mental hospitals of NSW.⁸ Dr W Ernest Jones, the Inspector-General of the Insane for Victoria, noted that, in 1913, 88 cases of GPI had been admitted to Victorian mental hospitals but, by 1932 that number had dropped to 26.⁹ Jones attributed this improvement to better hygiene and better social discipline but also to the availability of Salvarsan and malarial pyrotherapy as treatments for GPI.⁹ However, there were many problems associated with the use of Salvarsan. It was less effective in cases of GPI than it was on *Treponema pallidum* during the earlier phases of syphilitic disease. Salvarsan was difficult to administer and had many unwanted effects. Yet its advent attracted great public interest and stimulated researchers and drug companies to search for more 'magic bullets.' Despite various problems in its administration, efficacy and side-effects, Salvarsan remained in use until it was made obsolete by the introduction of penicillin. In 1917, the Austrian physician Dr Julius Wagner-Jauregg discovered that GPI could be improved by inducing a malarial fever in the patient, a treatment known as pyrotherapy. This was done by intravenous injections of plasmodium parasites. Pyrotherapy was employed for

many years in the mental hospitals of many countries, including Australia.¹⁰ Ehrlich was eventually awarded a Nobel Prize for his contribution to the treatment of syphilis and Wagner-Jauregg for his contribution to the treatment of GPI.

When, on his return to England from New South Wales, Sir John Macpherson delivered the ninth Maudsley Lecture, he proposed that recent successes in the treatment of GPI offered a paradigm for future research concerning the origins and the treatment of the common psychiatric disorders:

This therapeutic method, though disappointing in some of its results, is significant as a means of restoring cortical equilibrium which has been disturbed by disease. If this method is not itself perfected it will certainly be replaced in the near future by some similar and more effective agency.¹¹

9.5 Biological therapies for the management of psychosis

Four biological treatments for psychosis were invented in Europe during the 1930s and soon reached NSW. These were Cardiazol convulsive treatment, insulin coma therapy, electroconvulsive therapy (ECT) and psychosurgery. They are sometimes known as ‘physical treatments’, ‘organic treatments’ or ‘biological therapies’ to differentiate them from psychological, psychosocial and behavioural methods of treatment. The mechanism by which convulsive therapies relieve psychosis is imperfectly understood. It is thought that convulsions modify the availability of neurotransmitter chemicals that are essential for neuronal conduction. Two of the best known of those neurotransmitter chemicals are serotonin and dopamine.¹² The three convulsive therapies are described in the next three subsections. The fourth of those biological treatments— psychosurgery—is described in the last subsection.

9.5.1 Cardiazol convulsive treatment

In Budapest, in 1934, Dr Ladislav Meduna induced convulsions in psychotic patients by the intravenous administration of the drug pentylenetetrazol (hereafter referred to by the tradename Cardiazol). It was found that a series of these treatments, administered up to three times per week on more than a dozen occasions, could lead to the abatement of episodes of psychosis. However, there were several unwanted effects and successful treatment did not prevent the recurrence of psychotic episodes. The onset of convulsions after intravenous injection of Cardiazol was not immediate. In descriptions given by many patients, this lag between injection and fitting was very unpleasant and frightening. Another significant unwanted effect of treatment was the risk that vertebral bones would fracture during convulsions.

In 1938, the Inspector-General of Mental Hospitals for NSW, Dr Wallace reported that Cardiazol and insulin coma treatments had been introduced at several of his mental hospitals, including at Broughton Hall Special Hospital.^{13,14} In the same year the *Medical Journal of Australia* published a paper by Ellery and Lear about the use of Cardiazol treatment in a Victorian private mental hospital.¹⁵ In his Annual Report for 1939 Wallace reported that 450 patients who had schizophrenia and some patients who had manic-depressive illness had received Cardiazol treatment and that the results, especially in early cases, had been very favourable. Wallace added that Cardiazol had been ‘found more suitable generally than Insulin treatment.’¹⁶

In 1939, the Deputy Medical Superintendent of Bloomfield Mental Hospital at Orange, Dr Broughton Barry, published a comprehensive review of his experience with Cardiazol. Barry

reported encouraging responses in individual patients and a pleasing transformation in attitudes and morale in his hospital following the introduction of this new therapy. He also attributed the speedier discharge of many inpatients to the effectiveness of Cardiazol treatment.

During the year ended July 31st 1939 we treated with Cardiazol 42 newly admitted patients. This number was composed of 37 schizophrenics, three manic-depressives and two paraphrenics. Of that number, 22 have gone home, the condition of 11 is improved, mostly very much, in three the condition is not improved, and six are still under treatment; most of these are improving, and we expect more to go home.¹⁷

In addition to these newly admitted patients, Barry treated eleven chronic patients during the 1938-39 financial year. Totalling the results obtained by the treatment of these 53 subjects, Barry reported that 29 had a remission, 12 improved, and 12 had not improved. These were, in Barry's estimation, very favourable outcomes. Barry's clinical vignettes include accounts of emaciated and withdrawn patients who, but for Cardiazol treatment, would have required tube feeding to remain alive. Barry concluded that tube feeding would soon be a thing of the past:

The average length of time spent in hospital by the patients in this year's series who had remissions was fourteen weeks; their probable period in hospital before treatment with 'Cardiazol' was a lifetime. The average number of injections given in successful cases was fifteen to sixteen. ... There is a great difference in the atmosphere of hospitals now from what it was eight years ago when I entered the Mental Hospitals Department. They, especially the newer ones, become more

and more like a general hospital; difficult patients become fewer and fewer, and an atmosphere of friendliness and hope replaces the old one.¹⁷

The use of Cardiazol treatment to manage serious mental disorders is very relevant to the history of general hospital psychiatry for the fact that its employment in general hospitals was no more complex or difficult than it might have been in mental hospitals and in private mental hospitals. In 1939, Professor Dawson reported the outcomes of treatment for 33 patients, some of whom were treated at RPAH and some in his private practice. Most of these patients suffered from melancholia or schizophrenia, but a small number are likely to have been manic. According to Dawson, 18 of these patients went into a remission which persisted for at least three months after the last treatment, while the remainder showed either little or no improvement.¹⁸

9.5.2 Electroconvulsive therapy (ECT)

Electroconvulsive therapy (ECT) was first employed by Ugo Cerletti and Lucio Bini in 1938, in Rome, to treat psychosis. It soon became clear that most psychotic conditions responded to ECT, but unwanted effects could include memory loss and vertebral fractures. ECT came into regular use in most Western countries in the early 1940s. In 1940, the superintendents of mental hospitals in NSW asked the Lunacy Department to ensure that they would be supplied with ECT machines.¹⁹ According to Mitchell and Sengoz (1995) the first ECT machines only became available in Australia in 1942 when the first such device was built and put to use at Glenside Hospital in Adelaide.²⁰ By 1945, most mental hospitals in NSW had ECT machines.²¹ As these machines became available throughout NSW, it became clear that the outcomes afforded by ECT were very similar to those provided by the administration of Cardiazol. Cardiazol therapy fell out of use because it had no inherent advantages over ECT.

It was difficult to control the duration of the convulsions caused by Cardiazol and the injections caused terrified experiences in patients. In the twenty-first century, ECT continues to be an essential agent in the management of intractable cases of melancholic depression and in the management of several other psychotic conditions. In NSW, in 2022, ECT is employed in most general hospital psychiatric units, in private psychiatric hospitals and in the remaining mental hospitals.

9.5.3 Insulin Coma Therapy (ICT)

Insulin coma therapy (ICT) for psychosis was introduced into psychiatry by the Austrian psychiatrist, Manfred Sakel, in the mid-1930s. As was the case of ECT, its potential use and efficacy quickly became evident. The mechanism by which ICT works is not clear, but ICT was frequently associated with convulsions, and the explanation for its effect on psychosis may lie in the release of neurotransmitter agents during those convulsions. ICT was effective in terminating psychosis in many patients, but there were significant problems associated with its administration. ICT induced a hypoglycaemic coma which, if mismanaged, could lead to brain damage and death. The safe use of ICT required nursing staff who had been specially trained to and who were well qualified to manage comatose and semi-comatose patients. Insulin Coma clinics were, consequently, very labour intensive, and expensive to maintain.

It seems that ICT was first effectively employed in private clinics and mental hospitals in Victoria in 1936 or 1937, and that NSW was slow to follow suit.²² The Annual Report of the Inspector-General for NSW in 1952 recorded that Insulin Coma clinics were installed in the previous year in several of NSW's mental hospitals.²³ In 1955, Stoller and Arscott reported that modified Insulin Coma Therapy was being employed in mental hospitals throughout

NSW as well as at RPAH and Concord Repatriation Hospital.²⁴ However, ICT clinics were destined for abandonment by the end of the decade after carefully designed studies in the UK and the USA demonstrated that the outcomes of ICT were no better than those offered for schizophrenic psychosis by the use of the drug chlorpromazine and because of the high morbidity and the expenses associated with the use of ICT.²⁵

9.5.4 Psychosurgery

The invention of modern psychosurgery is usually attributed to Portuguese neurologist António Egas Moniz. In 1935-1936, Moniz encouraged Alberto Lima, a neurosurgeon and staff member in Moniz's medical team, to perform operations on the prefrontal cortex of a series of mentally ill subjects. This procedure, known as prefrontal lobotomy was promoted in the USA by Dr Walter Freeman. Following its popularity in the US, the procedure quickly spread to the UK and to other Western nations. It was introduced into Australia in either 1945 or 1946, where its popularity was rather short-lived; by the mid-1950s the frequency of its use was waning.²⁶ However, modified operations called prefrontal leucotomies were occasionally employed in NSW until the late 1970s, mainly for the management of chronic depression and chronic obsessional disorders. Prefrontal lobotomies and leucotomies were performed at Sydney's major general hospitals as well as some of its private hospitals between 1950 and 1979 but in smaller numbers than in the UK or the USA. Psychosurgery was outlawed in NSW by the Mental Health Act of 1990.²⁶ Adverse publicity for psychosurgery in NSW during the 1970s, led to a legal ban on psychosurgery and for electrode implantation and stimulation for psychiatric disorders. Therefore, while psychosurgery is relevant to the history of psychiatric practice in NSW, it is not a part of its contemporary practice.

9.6 Antipsychotic Drugs

Synthesized in the laboratories of Rhône-Poulenc as a potential anti-histaminic drug, chlorpromazine (hereafter, CPZ), was found to have some quieting effects on medical patients. Following tests on psychotic patients who were hyperactive, CPZ came to be the world's first truly effective antipsychotic drug. In 1952, French psychiatrists Jean Delay and Pierre Deniker published favourable treatment outcomes following the prescription of CPZ to patients who suffered from a variety of severe mental disorders.²⁷ Reports about the efficacy of CPZ in the management of schizophrenia multiplied as prescriptions for its use escalated across the planet.²⁷ Nevertheless, there were mental health professionals who doubted the prediction that the advent of CPZ would lead to radical changes in psychiatry. Their scepticism was based, in part, on the failure of the biological treatments of the 1930s and 1940s, to justify the great euphoria that had surrounded their introduction. Psychosurgery was a case in point. The most persistent and vocal sceptics of CPZ were psychoanalysts and psychoanalytic psychotherapists. Many of them held that it was foolish to expect that the cure of psychiatric disorders was possible without the reorganisation of deeply embedded psychological structures through a psychotherapeutic intervention.

In 1955, two antipsychotic agents, chlorpromazine and reserpine, were introduced into the psychiatric services of NSW.²⁸ Reserpine had effects on hypertension as well as on psychosis, but chlorpromazine (CPZ) was certainly more often effective against psychosis. CPZ had several unwanted effects including anticholinergic effects and toxicity to the liver. Some of chlorpromazine's successors had fewer of chlorpromazine's unwanted effects, such as drowsiness, but had a greater tendency to cause problems that included parkinsonism and dyskinesias. Consequentially, the prescription and follow-up of patients on antipsychotic drugs required, and continues to require, considerable vigilance. Between 1956 and 1961, the

world's leading mental health professionals were drawn into many discussions and debates about the treatment of psychosis by the prescription of CPZ and the antipsychotic drugs that succeeded it. These professionals quickly realised that new research protocols were needed to allow accurate evaluation of the efficacy and unwanted effects of these new agents. A Psychopharmacological Service Centre was therefore created within the National Institute of Mental Health (NIMH) and, in 1961, a sophisticated double-blind multi-centre randomised controlled trial began to evaluate the efficacy of three phenothiazine drugs (including CPZ) when compared with a placebo. The study engaged a population of about 400 newly admitted patients who had a diagnosis of acute schizophrenia to nine major hospitals in the USA. The results were very encouraging.²⁹ Ninety-five percent (95%) of the drug-treated patients showed improvement following six weeks of treatment compared with twenty-three percent (23%) in the placebo group. The incidence of side effects was low. The active drugs were effective on many aspects of psychosis whether the patients were, or were not, hyperactive. Researchers also concluded that their study supported the increasing professional confidence and optimism concerning the treatment of acute schizophrenic psychoses. Moreover, the efficacy and feasibility of drug treatment had great potential for encouraging the development of a public health approach to the treatment of acute schizophrenic psychoses and the prevention of chronic disability.²⁹ The publication of the outcomes of that study made it widely known that the newly invented antipsychotic drugs were, indeed, the agents of '*anti-psychosis*' that Daniel Hack Tuke had feared might never be discovered. The mechanism by which antipsychotic drugs work on the brain is complicated, partly unknown, and has been much debated, but experts mostly agree that antipsychotic drugs have their main effect on psychosis by their action on receptor sites on neurones which are responsive to the neurotransmitter and hormone called dopamine.¹²

Edward Shorter has characterised the introduction of chlorpromazine into clinical practice as one of the great advances in the history of psychiatry.³⁰ Dr Archibald Cochrane, who is regarded as a strict arbiter of the value of medical treatments, concluded that CPZ was effective against schizophrenic psychosis. In 1972, Cochrane wrote that the efficacy of antipsychotic drugs like CPZ had been proven but added that antipsychotic drugs were not always employed efficiently. Cochrane noted two factors that accounted for the discharging of many patients from the mental hospitals during the preceding decade: (1) a marked change in social attitudes leading to the permissive society and (2) 'a great increase in the discovery and marketing of psychotropic drugs'.³¹ Cochrane continued:

Both factors have probably helped to empty the mental hospitals into the community. This is mainly due to discharging schizophrenics. In the 1930s about 60 percent of these stayed at least two years in hospital, now only 10 percent stay as long. There seems reasonable evidence that phenothiazine improves the symptoms of schizophrenia in the short term, but there is much more doubt about long-term effects.³¹

In 1980, in a lecture on the relationship between psychiatry and general medicine, Professor David Maddison stated that the reputation of psychiatry had greatly improved in the preceding decades. 'I surely do not need to document my contention that psychiatry has attained a new level of respectability, within society and within the medical profession as a whole.'³² Maddison then acknowledged that the advent of antipsychotic drugs had played a significant part in the emptying of many wards in mental hospitals, but stated his conviction that the relevance of antipsychotic drugs had probably been over-rated:

Some will want to place great importance on the fact that the major tranquillisers have been an important influence (perhaps not the only influence) in the

progressive opening up of the psychiatric hospital, in the implementation of more progressive admission and discharge policies, and in the recruitment of more highly motivated staff to work in the wards of such hospitals; these matters can hardly be denied, but I seriously doubt whether they have had the revolutionary effect that their fervent protagonists would like to maintain.³²

Maddison might have been right, but this does not mean that he was in synchrony with most of his academic colleagues. The discrepancy between Maddison's views about the relevance of psychopharmacological agents on the historical development of psychiatry and the views of many of his colleagues does not appear to have diminished Maddison's influence within the Australian medical profession and on medical education. There is more about Maddison's career and about his impact on Australasian medicine and psychiatry in *Chapter Eleven: The impact of psychiatry on medicine: Maddison and Pilowsky*.

During the 1960s, intramuscular depot injections of antipsychotic drugs were introduced and marketed for their potential to assist in the management of chronic psychosis—especially schizophrenia—by injections at monthly intervals. The availability of depot antipsychotic drugs has facilitated the discharge of many chronic patients from mental hospitals, enabling and empowering them to live in community settings. Because depot antipsychotic agents are often employed to ensure compliance, it was inevitable that their use would be controversial. Legal and ethical questions related to their employment in the management of chronic psychosis in community settings are discussed in *Chapter Ten: A Renaissance in psychiatry in New South Wales*. In 1967, an important antipsychotic agent called haloperidol was approved for the treatment of schizophrenia by the Food and Drug Administration of the USA. Haloperidol, and a similar agent called droperidol, affect behaviour very rapidly when

administered by intravenous or intramuscular injection. They are frequently used in crisis situations to control psychotic episodes related to schizophrenia, manic-depressive disorder, delirium or psychosis caused by street drugs like crystal methamphetamine ('ice').³³ Haloperidol and droperidol are considered invaluable by many doctors and nurses in emergency departments as well as in the medical and surgical wards of general hospitals where they are usually administered by physicians who are not psychiatrists. There is not an emergency department in the general hospital of any city in Australasia that does not employ parenteral antipsychotic agents, often at the same time as rapidly acting benzodiazepines to manage acute psychosis. This type of emergency treatment has been labelled 'rapid tranquillisation' or 'rapid neuroleptization.'³⁴ The ethical implications of 'rapid neuroleptization' to control psychotic behaviour has attracted the attention of many critics who are concerned about the potential abuse of civil liberties through tranquillisation and 'chemical restraint'.^{34,35,36}

One of the earliest discovered antipsychotic drugs, clozapine, was sidelined for two decades because of its association with cardiac complications and with serious blood disorders, including agranulocytosis. In the 1980s, further clinical evaluation of clozapine led to the discovery that it might relieve psychosis in certain cases of schizophrenia that had not responded to other agents. This led to the reintroduction of clozapine into clinical practice in the 1990s.

9.7 Antidepressant drugs

In 1952, researchers who were examining the drug iproniazid for its potential as a treatment for tuberculosis noted that it relieved the depressed state of some of the subjects who were involved in their study. Iproniazid did this by inhibiting the enzyme that broke down

circulating amines, including serotonin and norepinephrine. These amines are both neurotransmitters implicated in the maintenance of mood. These discoveries led to the introduction of a group of antidepressant drugs that came to be called monoamine oxidase inhibitors or MAOIs. Within a few years, it became apparent that the use of MAOIs could cause hypertensive crises, especially when taken at the same time as certain foods or certain other drugs. As less toxic antidepressant agents became available, the MAOIs lost some of their popularity, but they remain in our contemporary clinical repertoire because they are specifically effective in certain less common forms of depression.

Reports from Switzerland that the tricyclic compound, imipramine, might relieve depression, began to appear in the mid-1950s and open trials suggesting its efficacy were published in 1957. One of the first of the controlled trials for efficacy, in 1959, was conducted in Britain by Drs Leslie Kiloh and Richard Ball, both of whom migrated to Australia in 1962.³⁷ Kiloh gained a favourable international reputation for his publications concerning the diagnosis and the management of affective disorders. It soon became clear that imipramine and its successors were most effective when used to treat forms of depression that had biological features, such as retarded thought and movement, sleep disturbance and weight loss. These are the features of a condition that, a century earlier, had been called melancholia or melancholic depression. However, tricyclics could also be useful in the management of less severe depression and in the management of certain anxiety disorders, including panic disorders and obsessive-compulsive disorders. Depression and anxiety are common in the general community, and antidepressant drugs were welcomed by many patients who suffered from those conditions. The popularity of antidepressant drugs has been phenomenal. A year after imipramine was released in the USA it had been used by 400,000 Americans. In the USA, prescriptions for antidepressant drugs grew exponentially. The popularity of

antidepressants followed a similar trajectory in NSW. Between the late 1950s and the present day, many new antidepressant drugs have been introduced. They vary considerably in their efficacy and in their side effects. The advent of the antidepressant drugs was less relevant to the emptying of the mental hospital wards than the arrivals of ECT and antipsychotic drugs, but antidepressants quickly became extremely important agents in the management of depressive and anxiety symptoms in general hospital psychiatric inpatient units, in general hospital outpatient clinics, in community mental health clinics, in private psychiatric hospitals and in the office practice of private psychiatrists and general practitioners.³⁸

Although the efficacy of antidepressant drugs has sometimes been questioned, there is some scientific consensus that, when used properly, they are more efficacious than placebos.^{39,40} This finding led to a key by which researchers began to identify the biochemical correlates of mood disorders in the brains of depressed patients. Of the dozens of neurotransmitters in the human brain that have been studied, the ones that seem most relevant to the regulation of mood and mood disorders are, at present, thought to be serotonin and noradrenalin. Researchers have therefore focussed on the creation of drugs that affect the serotonin and noradrenalin receptor sites on the surface of neurones. Drugs that affect serotonin receptors produce fewer unwanted effects in patients than those that affect noradrenalin sites; this realisation led to the creation and the commercial production of selective serotonin reuptake inhibitors (SSRIs). The first SSRI to hit the world markets was fluoxetine (Prozac), which was discovered by Eli Lilly and Company in 1972, and was introduced into medical practice in 1986. One of its successors, sertraline (Zoloft) entered the American market in 1991 and the Australian market in 1994. It quickly became the most frequently prescribed antidepressant in Australia.

9.8 Mood stabilisers

In 1948, the Victorian psychiatrist, John Cade discovered the potential value of lithium carbonate as a treatment for manic excitement.⁴¹ A year later he published his findings in the *MJA*.⁴² However, shortly after its introduction into clinical practice lithium carbonate was found to cause fatalities and its use was hastily abandoned. Two decades later it was demonstrated that lithium could be employed safely if its levels in the bloodstream were regularly monitored to ensure that the dosage was sufficient to reach a therapeutic threshold but lower than the level at which it would be toxic. Lithium can be used to treat acute manic states, but it is especially useful when employed to maintain mood stability in persons who have a bipolar disorder diathesis. Access to lithium carbonate treatment has allowed many patients to gain control over the frequency of their episodes of mood disorder and the frequency of hospitalisation, which has allowed many of them to lead relatively independent lives. Several anti-epileptic drugs, including lamotrigine, can also be used as mood stabilisers. It has also been realised that some recently introduced antipsychotic drugs have preventive or ‘prophylactic’ capacities in relation to attacks of mania and depression and are therefore sometimes useful as mood stabilisers. In the brain, lithium affects neuronal release of serotonin and noradrenalin, but the mechanism by which it regulates mood. is not perfectly understood.

9.9 Benzodiazepines

The benzodiazepine group of drugs were synthesized in the 1950s and came into clinical use in the 1960s in the form of sedatives and hypnotics. Because most of the long-acting and short-acting benzodiazepines caused less respiratory depression than barbiturates, it was realised that they were less dangerous if taken in overdose. Benzodiazepines therefore quickly replaced barbiturates as sedative-hypnotics. Among the best known of the earliest

benzodiazepines were diazepam (Valium) and nitrazepam (Mogadon), which were respectively used to treat anxiety and insomnia. Many years would pass before the potential of benzodiazepines to lead to addiction was fully appreciated, and for their long-term use to be discouraged.

The short acting benzodiazepines, which include midazolam and lorazepam, can be used to quickly bring certain agitated patients to a calmer state. Given intravenously, midazolam can be used to sedate a severely agitated patient in less than thirty minutes. Nonetheless, benzodiazepines do not directly control psychotic processes. Therefore, to speedily control violent psychotic behaviour, midazolam or lorazepam are sometimes administered at the same time as an antipsychotic drug like haloperidol.^{34,43} Midazolam must be used expertly and with great caution because it causes severe respiratory depression, which can be fatal. In emergency departments and elsewhere in general hospitals, where severe agitation can pose hazardous scenarios for patients and for staff, midazolam is considered a valuable agent. However, it is understood by clinicians that delusions, hallucinations and other psychotic thought processes are not prevented or reversed by the unaccompanied administration of midazolam or other benzodiazepines.

9.10 Conclusions

The introduction of biological treatments, especially Cardiazol in the late 1930s and ECT in the early 1940s, and various psychoactive drugs, such as chlorpromazine in the mid-1950s, has had a profound impact on the development of general hospital psychiatry, and on the place of psychiatry in general medicine in New South Wales. The advent of these new biological treatments has had wide ranging consequences, including:

1. Episodes of major psychiatric disorder can usually be halted by the administration of certain drugs, or, in otherwise intractable cases, by the administration of ECT.
2. Because psychiatry and general medicine both rely heavily on the use of biological treatments, and especially on the use of drugs, the practice of psychiatry has become conceptually closer to general medicine than was previously the case.
3. Between 1961 and 1994, the use of biological treatments, including psychoactive drugs, has led to the removal of many beds and many wards from mental hospitals.
4. The availability of the new convulsive and drug treatments has greatly facilitated the management of acute psychotic episodes in the psychiatric inpatient units of general hospitals and in the non-psychiatric wards and emergency departments of general hospitals.
5. By the employment of psychoactive drugs and, less frequently, by the administration of other biological therapies, chronic psychosis could often be managed in community settings without recourse to admission for inpatient management.
6. The frequency of attacks of certain recurrent mental disorders could be reduced by using mood stabilisers. Their availability has allowed many persons who were liable to mood disorders to lead lives that were less affected, or minimally affected, by mental illness.
7. The new drug treatments could be provided by health professionals at community clinics, at general hospital outpatient clinics and in the offices of GPs and psychiatrists in private practice.
8. These new biological treatments could reduce the mental disorders of many patients to the degree that they could begin to benefit from psychotherapies, psychosocial therapies, educational programs and rehabilitation programs.

The next chapter—*Chapter Ten*—will describe the remarkable transformation of the psychiatric services of New South Wales that occurred between 1961 and 1994. The most

dramatic of these changes would not have been possible without the advent of the new biological agents. The availability of these agents greatly altered the trajectory of the development of the world's psychiatric services during the second half of the twentieth century.

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Chapter Ten

A renaissance in psychiatry in New South Wales (1961 to 1994)

10.1 Introduction

Chapter Ten describes remarkable advances in the psychiatric services of New South Wales that commenced in the 1960s. The availability of new biological treatments for psychosis, most obviously in the form of drug treatments, made it possible to manage psychosis in many settings, including within the wards of the general hospitals. In 1961 a massive migration of mental health professionals into the general hospitals of NSW was about to commence. However, before this could happen, the NSW Government would be forced to devise and to implement radically new policies concerning general hospital psychiatry and community health services.

10.2 The psychiatric services of New South Wales emerge from the shadow of the Second World War

In September 1945, when Australia emerged from a decade of economic depression followed by six years of global warfare, its citizens realised that they had been spared the worst of the hardship and pain and that had overtaken many other nations. There was a national sense of deliverance but it was tinged with fatigue. There was plain evidence of human suffering as Australian ex-servicemen returned from Asian prison camps and refugees began to arrive from war-torn Europe, but the damage to the patients in the mental hospitals remained hidden from public view. For a decade after 1945 Australia went through a phase of repair and reconstruction but the dismal conditions within the mental hospitals were overlooked until 1955. In that year, the extent of the neglect within the mental hospitals was exposed by the Stoller and Arcscott Report on the mental health facilities of Australia. The *Report* singled out

NSW as deserving of its harshest criticisms.¹ In the same year, a remarkable new antipsychotic drug called chlorpromazine reached New South Wales and brought new hope for the control of insanity. A year later, in 1956, Dr Bill Trethowan arrived in Sydney from Birmingham to accept the Chair of Psychiatry at the University of Sydney, which had been vacant for five years.

Professor Trethowan was an inspirational figure whose intellect and vigour were obvious to the medical profession, to the NSW Government and to the local media. Trethowan was genuinely worried about the plight of patients in the antiquated mental hospitals and was intent on creating a revolution in the State's psychiatric services. One of Trethowan's main strategies was to promote the transfer of acute psychiatric services into the general hospitals where the attitudes of doctors and nurses might be less pessimistic and demoralised than those in the mental hospitals, and where the management of mental disorders should be less restrictive and therapy more effective. Trethowan expressed the belief that general hospitals could provide a base for the introduction of preventive psychiatry to adjacent communities. On the last day of 1958, a radically new Mental Health Act, which contained most elements of Trethowan's philosophy, would come into effect in NSW.

In 1956, when Trethowan arrived in Sydney, the Honourable William ('Billy') Sheahan became the Minister for Health for New South Wales. Sheahan was an energetic and gifted but combative and controversial politician.² Sheahan had managed several ministerial portfolios in the NSW Labor Government of Joe Cahill including that of Attorney-General. His outstanding achievement in that ministry had been the abolition of capital punishment in NSW. Dr Cyril Cummins, who, because of his service as the Director-General of Public Health between 1959 and 1975, was well placed to judge the performance of health ministers,

recorded that ‘... the most interested and vigorous Minister of my experience was the Hon. William “Billy” Sheahan, during whose period significant changes took place in health administration.’³ According to Cummins, Sheahan supported the reformation of mental health services as vigorously as he supported the officers within the Health Department who battled to effect sometimes painful and difficult changes.⁴ At the commencement of the 1960s, pieces were falling into place for a major transformation of psychiatry in NSW. However, something more was needed to propel change.

In 1961 the McClemens Royal Commission of Inquiry concerning Callan Park Mental Hospital drew the attention of the broadcast media, and, consequently, that of the citizens of NSW, to the wretched state of the mental hospitals and to various other deficiencies in the mental health system. The NSW Government realised that, if it hoped to meet the public demand for better health services, it had no option but to push through new policies concerning preventive psychiatry, preventive medicine, public health and community health. New policies would not work unless the Government was able to overcome the relative indifference of the medical boards of the general hospitals to government policies and to the health needs of geographic communities. The NSW Government understood that it needed more direct control over the general hospitals and health professionals of NSW. It also recognised that it needed the power to appoint mental health professionals directly into community settings. In those years, general hospitals were loosely administered by a statutory body called the Hospitals Commission. Before the NSW Government could propel psychiatry into the general hospitals, and into adjacent communities, it would have to reshape the administrative and legal structures which maintained its health services. To guide these difficult reformations the NSW Government set up the Health Advisory Council.²

10.3 The Health Advisory Council (1961 to 1973)

The Health Advisory Council had five members. The Chair was Dr Cyril Cummins.

Professor Trethowan was a member of the Council until 1962 when his return to Britain led to his replacement by Professor David Maddison. The other members were Sir Edward Ford, who held the Chair of Preventive Medicine at the University of Sydney, Dr John Lindell, the Chair of the Victorian Charities and Hospital Commission and Mr CR Hicks, the former Director of the NSW Child Welfare Department. The Health Advisory Council quickly set to work planning the reorganisation of the psychiatric services, the developmental disability services and the geriatric services of NSW. During 1961 and 1962 the Council issued three Interim Reports.

The First Interim Report on Preventive Psychiatry (dated June 1961) would have profound consequences. The Report introduced the concept of preventive psychiatry into NSW. In doing so, it provided the philosophy that would guide the future of the State's mental health services; it determined the functions that the existing facilities, including general hospitals, would perform in the new health system and it determined how mental hospitals would lose their isolation from general medicine. Six ambitious clinical projects originated from the First Interim Report. A diagnostic, early treatment and rehabilitation facility called Cumberland House was created in the City of Parramatta. This was an inpatient unit for short-term voluntary treatment. It was constructed adjacent to Parramatta Mental Hospital, which provided all the necessary clinical staff for its operation. The Darlinghurst Reception House was converted into the Caritas Centre—a psychiatric inpatient, outpatient and day-hospital complex attached to St Vincent's Hospital. A psychiatric inpatient, outpatient and day-hospital was created at the Royal North Shore Hospital. A large and elaborate day hospital and outpatient complex was created at the Broughton Hall Special Hospital. The academic

psychiatric facility that had been operating at RPA Hospital since 1938 was updated and enlarged. Physical facilities at Callan Park Mental Hospital were reconstructed to create a new admission centre with the potential to provide short-term psychiatric treatment.² According to Cummins, a remarkable feature of this period of reform was that all these projects were planned and completed within a period of three years from the publication of the First interim Report.² In association with those projects in Sydney, a community-focused inpatient, day-hospital and outpatient facility was created adjacent to the Watt Street Mental Hospital at Newcastle.

The Second Interim Report on the Care of the Aged, and the Third Interim Report on Intellectually Handicapped Persons were issued, respectively, in March and in October of 1962.² Those reports were concerned with the medical and psychiatric management, accommodation and financial and social needs of many persons who had, for many decades, been consigned to mental hospitals. It was clearly inappropriate that persons who were demented or developmentally delayed should languish in mental hospitals alongside persons who were suffering from delusions, hallucinations and irrational behaviours. Therefore, in the 1960s, 1970s and 1980s many patients in those categories were discharged from mental hospitals and into nursing homes or supervised accommodation. Of course, persons who had dementia or developmental disability were never rehoused in the beds of general hospitals. The general hospitals had never been designed to provide comprehensive services--accommodation, bodily care and financial and social support--that had sometimes been available to patients in the best of the mental hospitals.

10.4 Rapid and dramatic change within the mental hospitals: 1962 to 1967

Between 1962 and 1967, there was a twenty percent reduction in the resident population of the mental hospitals accompanied by a rapid increase—more than a doubling—of the annual rates of admission and discharge.⁵ The availability of chlorpromazine certainly contributed to these outcomes but Cummins also attributed these welcome results, and the much improved morale of the staff of the mental health service, to the great abilities of the incoming Director of the State Psychiatric Service, Dr Bill Barclay. According to Cummins, Bill Barclay saw the mental hospital system:

... as the instrument which should be stimulated to provide a statewide service. In this concept he was supported by Dr E Cunningham Dax, who could point to his results in Victoria. If there was one psychiatrist within the Department who could implement this policy it was Dr Barclay, and he proceeded to do it immediately and vigorously.⁵

[and]

Not since Norton Manning's time has there been so much responsibility thrust upon the Head of Psychiatric Services. Certainly, in no previous era has so much been accomplished in one decade.⁵

In his Annual Report for the year ending June 1963, Barclay detailed a plan for 'Regional Psychiatric Services'.⁶ Here, the term 'regional' is not used in reference to rural geography. Rather, 'regional' describes clearly demarcated administrative areas—local government areas. These geographic areas were also colloquially known as 'catchment areas.' In his 1963 report, Barclay stated that 'admission centres' should be established throughout NSW in general hospitals or in mental hospitals. Such centres, continued Barclay, would be gazetted to allow mentally ill persons to be involuntarily admitted and managed under the Mental

Health Act (1958).⁶ Well-delineated geographic communities would eventually become the responsibility of the mental health professionals who directed these ‘admission centres.’

Between September 1964 and February 1966, while funded by a Harkness Fellowship, Barclay visited the USA and the UK to study psychiatric services.⁷ Barclay spent most of his time in New York and in Boston. In his Harkness Fellowship Report he describes having been particularly impressed by programs affiliated with Columbia University in New York, and by psychiatric services in Massachusetts led by Dr Gerald Caplan. In the Recommendations section of his Report, Barclay has this to say about general hospitals:

General hospital psychiatric units should henceforth be supported by the State only with the proviso that a regional comprehensive community service be provided [...] The general hospital should not be perceived as the only possible model for regional mental health services. The establishment of independent community mental health centres is an equally important model for the provision of services particularly in the metropolitan area.⁷

Here Barclay drew attention to the fact that the Federal Government of the USA had created certain community mental health clinics which had no links with general hospitals. Barclay emphasised the possibility of creating community services without the cooperation of general hospitals but he did not explain how he thought community mental health clinics could maintain relevance within the psychiatric services if they had no direct access to acute psychiatric inpatient services in general hospitals or in mental hospitals.⁷

In his Annual Report for the year 1966-1967, Barclay described a scheme for the stepwise creation of a comprehensive psychiatric service for NSW which he divided into four phases.⁸ The first three phases of the program concerned the mental hospitals, as follows:

1. The metropolitan mental hospitals, including Broughton Hall Special Hospital and Rydalmere (psychogeriatric) Mental Hospital, would each have a defined area from which they would receive patients and for which they would have ‘the total responsibility of providing a psychiatric service’.⁸ Outside the metropolitan area, the demarcation of the boundaries of catchment areas would be determined at some future date and would be linked to the various country mental hospitals.⁸

2. Within the metropolitan mental hospitals, sub-regional clinical teams would accept responsibility for the management of communities of between 15,000 and 25,000 persons from specified local government areas.⁸

3. The third phase would see the decentralisation of staff and services to attend to those delineated local communities. This would require the recruitment of additional staff: nurses, doctors and other health professionals would form early assessment (mental health) teams which would be responsive to requests by local GPs and local hospitals, and which would provide domiciliary services to persons in need. Staff of the clinics would provide follow-up and after-care services. The community mental health teams would require offices in buildings which were close to the homes of the clientele for whom the services were intended. Those buildings might house several clinical teams and would provide mental health services for populations of between 50,000 and 100,000 persons.⁸

The fourth phase of the plan, which focussed on the general hospitals, was foreshadowed by Barclay but was not an immediate prospect in 1966-67. Inpatient psychiatric services would be established ‘on a regional basis at selected general hospitals.’ These would cater for communities of 200,000 to 250,000 persons by the provision of 0.4 psychiatric beds per

1,000 population. These general hospital inpatient units would initially be staffed by teams from the mental hospitals and would provide short-term acute inpatient care and longer-term inpatient care if that became necessary. Continuity of management for individual patients would be guaranteed because clinical staff would be expected to accept responsibility for individual patients, whether those patients were hospitalised or were managed in the community.⁸

10.5 The creation of voluntary-admission acute psychiatric inpatient units in the general hospitals of NSW in the 1960s

The 1960s witnessed the rapid construction and opening of acute psychiatric facilities in four major general hospitals in Sydney: St Vincent’s Caritas Centre, and Royal North Shore Hospital’s CJ Cummins Unit, both in 1965, and St George Hospital’s Pacific House, and a facility at Prince Henry Hospital in 1966. (See List One: General Hospital Psychiatric Units in Sydney). These units joined two other general hospital psychiatric facilities, at RPAH and at Concord Repatriation Hospital. Each of the four new facilities offered voluntary inpatient, outpatient and day-hospital management. The newly constructed, fifty-bed, academic psychiatric facility at Prince Henry Hospital provided teaching and research resources for Dr Leslie Kiloh, who had migrated from Britain in 1962 to accept the foundation Chair of Psychiatry at the University of New South Wales.

*

List One: General Hospital Psychiatric Inpatient Units in Sydney #

	<u>Opening of Psych Unit</u>	<u>Year of Gazettal</u>
• Royal Prince Alfred	1938	1993
• Concord Repatriation	1942	2010
• St Vincent’s Darlinghurst	1965	1976
• Royal North Shore	1965	1983

• St George	1966	1986
• Prince Henry	1966	1992
• Prince of Wales	1977	1977
• Westmead	1978	1994

Notes re General Hospital Psychiatric Inpatient Units in NSW:

This list does not include all the general hospital inpatient units created in NSW after 1966. Sydney Hospital has never possessed psychiatric beds.

Prince of Wales Hospital acquired psychiatric beds in 1977, all of which were gazetted.

The psychiatric beds at Prince Henry Hospital were gazetted in 1992 but those beds were closed in 1998 when the last of the psychiatric services moved to the Prince of Wales Hospital.

*

It is important to bear in mind that none of the psychiatric units built between 1962 and 1966 were designed to house patients held involuntarily under the Mental Health Act of 1958, and that no units had clearly defined responsibility for geographically delineated communities.

Admission into the new psychiatric units followed the same processes as those for medical and surgical patients; admission was at the discretion of honorary consultant psychiatrists or of a growing cadre of salaried psychiatrists called 'staff specialist psychiatrists'. The latter were employed on a full-time basis and were usually appointed as administrative directors of the new facilities.

With the opening of these acute psychiatric care facilities, each of these general hospitals acquired a department of psychiatry, staffed by psychiatrists, trainee psychiatrists, psychiatrically trained nurses and trainee nurses, clinical psychologists, psychiatric social workers, occupational therapists and other clinicians and support staff. In 1965, a 20-bed acute voluntary-admission inpatient facility was created four-hundred and sixty kilometres from Sydney at Wagga Wagga Base Hospital. In 1966, a small voluntary-admission inpatient service, day hospital and outpatient clinic called the Shortland Clinic was created at

Newcastle. By 1966, all the projects listed in the First Interim Report of the NSW Health Advisory Council had been completed.

In 1967, the *Medical Journal of Australia* published a comprehensive and thoughtful account of the above noted Caritas Centre by its Director, Dr John Woodforde.⁹ In this account, Woodforde clearly illustrated both the merits and problems associated with the creation of general hospital psychiatric units in NSW during the 1960s. For that reason, Woodforde's paper will be explored in some detail in several pages of this chapter.⁹ According to Woodforde, the Sisters of Charity had accepted the offer from the Department of Public Health to establish a 'community psychiatric centre' at St Vincent's Hospital in keeping with guidelines set by the Health Advisory Council in 1961. The resulting Caritas Centre would provide psychiatric out-patient, day-hospital and inpatient services for short-stay patients and would provide preventive psychiatry on a voluntary basis. The community responsibilities of the Caritas Centre were not listed or detailed and the geographic limits of any community responsibility were not delineated.⁹

At its opening, the inpatient unit at the Caritas Centre consisted of two 18-bed wards on separate levels of a newly constructed building. Woodforde reported that a third of inpatients were admitted by referral from non-psychiatric wards of St Vincent's Hospital, another third from local general practitioners and the rest from many sources such as private psychiatrists, social agencies, mental hospitals and other general hospitals. Self-presentation 'walk-ins' could be admitted if it were determined that inpatient management was warranted. The main diagnoses assigned to patients admitted in 1965 and 1966 were: psychophysiological and psychoneurotic reactions, personality disorders, schizophrenia, affective psychosis, and chronic brain syndrome. The majority (71%) of patients admitted were supported by private

insurance funds, while another 14% of patients were comprised of pensioners, whose admission and clinical care were financed by the Commonwealth Government. While the Caritas Centre tended to both sexes and housed patients between 11 and 79 years of age, the average patient was a 37-year-old male. The average duration of inpatient admission was about 30 days.⁹

The outpatient service at Caritas functioned from Monday to Friday. Most of the routine outpatient department (OPD) services were provided by honorary psychiatrists. Unheralded 'walk-in' outpatients were assessed by staff specialist psychiatrists. Emergency referrals and 'walk-ins' were immediately assessed for their suitability for management as day-patients, inpatients or outpatients. Questions concerning private insurance and the patient's ability to pay were part of this assessment process. A smaller proportion of outpatients possessed private health insurance than did inpatients, accounting for just under half of all outpatients.

Woodforde emphasized the point that treatment was financially challenging for those patients who were not pensioners nor in possession of private insurance. Universal health insurance, i.e. Medibank, would not be introduced into Australia until 1975. In the 1960s the private health insurance funds reimbursed patients for inpatient care but would not reimburse for day-patient attendance. Therefore, privately insured patients would be financially disadvantaged if they accepted treatment as day-patients. Yet, if the patients surrendered their rented accommodation to accept inpatient treatment, which would usually last about twenty days, they might not be able to find accommodation in their preferred community or near their workplaces when they were well enough to be discharged from inpatient care.⁹

The day-hospital at the Caritas Centre functioned from Mondays to Fridays in a building which formerly housed the Darlinghurst Reception Centre, and which abutted the newly constructed psychiatric inpatient building. Inpatient and day-patients mixed together in therapeutic activities such as small open groups, socio-drama group therapy and occupational therapy. On four mornings of each week, the treatment schedule would begin with a meeting attended by both patients and staff. The purpose of these large meetings was to review and to resolve any issues concerning the interactions of the patients and staff and other issues which might affect the social climate of the centre. In the decades of the 1960s and 1970s, such meetings were considered an essential component of a type of psychosocial treatment known as 'therapeutic community.' In the evenings, group therapy sessions and other group meetings were scheduled for the families of patients. Woodforde recorded limited information about the diagnostic categories of patients attending the day-hospital and did not record of the number of day attendees. A crude 90-day analysis of the characteristics of those attendees suggests that about half of them suffered from various degrees of depressive illness and close to a quarter suffered from schizophrenia. The average duration of attendance as a day-patient was 20 days.⁹

The senior medical staff at Caritas consisted of two full time staff specialists (including the Director) and six honorary medical officers. Honorary medical officers worked one to two half days each week. These consultant psychiatrists had one-to-one responsibility for the treatment of each patient and followed that patient through inpatient, day-patient or outpatient phases of management. Woodforde highlighted that honorary psychiatrists were not, in 1967, reimbursed for their services and, consequently, could not afford to spend as much time as they might have wished at Caritas. This impediment was removed in the 1970s, when most of

the honorary psychiatrist accepted new contractual arrangements and became visiting medical officers (VMOs). Thereafter they were well reimbursed for sessional attendances.

Two junior resident medical officers rotated through Caritas—each for terms of ten weeks duration. In 1966, the present author was one of those Junior RMOs. [Observations concerning the Caritas Centre are recorded in an appendix to this dissertation that is labelled Appendix Three: Professional Memoir.] Woodforde expressed hope that, in future years, Caritas would acquire two training Fellows from the Institute of Psychiatry. Other clinical services offered at Caritas were provided by one clinical psychologist, one occupational therapist and two social workers.⁹

Woodforde's paper emphasized how greatly the therapeutic environment of the Caritas Centre depended on the quality of the nursing staff. Half of the trained nursing staff had certificates in psychiatric nursing in addition to their certificates in general nursing. Woodforde noted the existence of a gap in salary scales, seniority recognition and prospects for superannuation for nurses at Caritas when compared with nurses employed by the state psychiatric hospital (or Fifth Schedule hospitals) system. Caritas nurses did not fare as well as their state hospital counterparts on each of these fronts. Woodforde noted that there were additional obstacles confronting any mental health professionals who wished to transfer their employment from State psychiatric hospitals to the general hospitals.⁹

In the final paragraphs of his paper, Woodforde outlined his therapeutic philosophy and his hopes for the future of the Caritas Centre. He strongly believed that Caritas, and other voluntary-admission general hospital psychiatric units, had a valuable potential; they were able to provide a modality of psychosocial treatment called 'therapeutic community'.

Woodforde believed that patients who participated in ‘therapeutic community’ programs, had a rare opportunity to learn how to confront difficulties in interpersonal relationships. Part of the ethos surrounding ‘therapeutic community’ was that patients be active agents in their own treatment. Patients were expected to participate in meaningful interaction with other patients, and were, sometimes, encouraged to accept partial responsibility for the behaviour of other patients. Woodforde argued for the maintenance of voluntary psychiatric units within general hospitals, such as the Caritas Centre, claiming that ‘therapeutic communities’ could only exist in places where there was a significant degree of freedom, trust and encouragement, something that he felt could not easily be duplicated in an involuntary psychiatric facility.⁹

Woodforde argued that the Caritas Centre should not hold responsibility for the mental health needs of delineated communities:

It is doubtful if the strict residential delineation of a community is appropriate for the psychiatric unit of a city general teaching hospital which has many patients referred for special investigation and treatment. A general hospital community psychiatry unit dealing with short-stay, non-statutory, voluntary admissions is compatible with the many needs of the local community.

It has been shown that there is such a high incidence of varied psychiatric illness in the highly crowded local community adjacent to this hospital that staffing and accommodation are inadequate to cope with all the demands. The responsibility of the unit to provide for the needs of the rest of the parent hospital must be considered too. It is generally accepted that facilities must be available elsewhere for the overflow of patients, particularly the violent and involuntary, the geriatric, and some other long-stay patients.⁹

Woodforde certainly knew that his proposals concerning the place of general hospital psychiatric units in mental health services were opposed to those of the leaders of the mental health services in Victoria and in New South Wales. In his *MJA* paper Woodforde referenced the book by Eric Cunningham Dax, in which Dax, who had recently been Chairman of the Victorian Mental Health Authority, had clearly stated a view that was diametrically opposed to that of Woodforde.

The fact is, the mental hospital and the early-treatment general hospital unit are both part of a psychiatric service, both are equally necessary and both are of equal importance. Nevertheless both are outdated. There never should be another mental hospital put up, anything like those in the past, but equally well I hope that there would be no more psychiatric wards in general hospitals of the type built in the past which were only suitable for the treatment of psychosomatic disorders, teaching and furthering the relations with general medicine.¹⁰

Woodforde's position was also at odds with the policy that was stated in the same year by Bill Barclay, who was then the head of the psychiatric services of NSW. During a Symposium held at the University of Sydney in August of 1967, Barclay informed participants, most of whom were senior mental health professionals, that the development of psychiatric services in NSW might resemble those of Britain but would differ in significant ways from the sequence that was being followed there.¹¹ Barclay announced the intention of the NSW Government to construct psychiatric clinics located away from general hospitals and mental hospitals, in buildings that were geographically located within the communities they would serve. These clinics, it was projected, would initially be staffed by mental health professionals from the existing mental hospitals. The next step would be to create admission

centres in general hospitals, designed and gazetted to allow the detention and treatment of patients according to the provisions of the Mental Health Act of NSW.¹¹ Barclay foreshadowed the fate of the six existing voluntary inpatient facilities in general hospitals in NSW. All six, he said, must eventually become admission centres. Barclay did not include the facility at Concord in his list because, in 1967, Concord Repatriation Hospital was the responsibility of the Commonwealth Government. Barclay stated that the general hospital psychiatric units would adhere to the policies of the NSW Department of Health, as follows:

First the unit must function as an admission centre with a regional responsibility for a defined geographic area. Sufficient beds must be provided for the unit to acquit this responsibility [...] The unit must accept responsibility not only for providing an in-patient service but must be firmly committed to developing a comprehensive community mental health service with a full range of domiciliary and community services.¹¹

An examination of the published transcript of the 1967 Symposium suggests that Barclay did not state that general hospital psychiatric units would initially be staffed by the sub-regional teams from the mental hospitals. Such a claim was, however, made in his Annual Report for the same year.⁸ It is still unclear whether Barclay deliberately avoided confronting his audience at the Symposium, many of whom worked at general hospitals, with a proposal that some would find objectionable. In any case, that aspect of the plan was never implemented, likely because it had the potential to generate discontent and strong opposition amongst those mental health professionals who worked in the general hospitals.

10.6 The academic psychiatric facility at RPAH in the early 1970s and the links between the new general hospitals and academia

One of the six general hospital psychiatric facilities to which Barclay referred was the academic department of psychiatry that was housed in the Psychiatry and Neurosurgery Pavilion at RPAH. That facility, led by Professor David Maddison, had been the epicentre of GHP in NSW since its opening in 1938. In the early 1970s, there were no satellites of the University Department of Psychiatry in the other general hospitals of NSW.¹² The clinical psychiatric service at RPAH was almost totally financed by the NSW Department of Health; the University of Sydney only provided financial support for three staff. The psychiatric service at RPAH catered mainly to patients who were suffering from non-psychotic anxiety and depressive disorders, mild personality disorders and anorexia nervosa but sometimes included a small number of patients who were psychotic but easily managed. Referrals for admission were accepted from the rooms of the three honorary consultant psychiatrists or from the medical and surgical wards and from the emergency department of RPAH via the consultation-liaison service. The inpatient service at RPAH had no catchment area and did not take involuntary patients. The patient population mostly reflected the professional interests of the consultant psychiatrists, one of whom was Maddison. There was an outpatient clinic which managed a caseload of mainly chronic psychiatric patients who exhibited a wider range of diagnoses. Undergraduate students rotated through the psychiatric service at RPAH and attended 'clinical demonstrations' at Broughton Hall Special Hospital and at the Callan Park/Rozelle Hospital.¹² According to Professor Bruce Singh, who had been a trainee psychiatrist at RPAH in the early 1970s, there was intense competition for registrar training appointments at RPAH, where trainees could count on excellent supervision in most aspects of psychiatry and in psychotherapy.¹² All the trainees were released for two days per week to attend the postgraduate course in psychiatry conducted at the NSW Institute of Psychiatry near Broughton Hall Special Hospital. Trainees also left the RPAH campus for terms of six months in psychiatric hospitals to gain experience in the rehabilitation of chronically ill

psychiatric patients and in the management of acute psychosis and brain damage.

Administrative arrangements within the RPAH Department of Psychiatry were strictly hierarchical. Some ward rounds were restricted to the medical staff. Research was a low priority and appears to have been an optional extra for those academics who could afford the time. According to Singh, few of the medical staff attempted higher degrees.¹²

Prior to 1978, when a new medical school was established at Newcastle, led by David Maddison there were only two medical schools in NSW: one at the University of Sydney, where Singh worked, and the other at the University of New South Wales. Both universities quickly sought to engage the consultant psychiatrists appointed in the new general hospital psychiatric units in academic activities. In return for their acceptance of responsibility for the supervision and education of medical undergraduates and for their engagement in research projects, selected consultant psychiatrists were offered academic titles. This arrangement greatly assisted both universities by providing additional staff resources without requiring new budgetary outlays.

10.7 The restructuring of the administration of health services in NSW and the creation of the Health Commission of NSW (1973-1982)

As noted earlier, the general hospitals and mental hospitals of NSW were administered via separate systems. The Minister for Health had direct control of the Fifth Schedule mental hospitals. However, his control of the general hospitals was seriously limited. It complicated matters further that the staff of these two administrative systems worked according to different conditions of service, pay scales, industrial and arbitration arrangements and were represented by different trade unions. Before the Minister for Health could hope to propel psychiatry into the general hospitals, or into delineated geographic communities, the NSW

Government decided to amalgamate the two systems. To commence these processes the Government created the Health Commission of New South Wales, which was directly answerable to the Minister for Health. The Health Commission was assigned the task of planning and effecting the transformation of the management of health services in NSW by the amalgamation of the general hospitals (which were loosely administered by the Hospitals Commission), the Schedule Five institutions, including the mental hospitals (which were administered by the Public Service Board), and the NSW Ambulance Service. The Health Commission of New South Wales was proclaimed on the 1st of April 1973. There were four Health Commissioners. Barclay was appointed Commissioner for Personal Health Services and had a key role in the effectiveness of the Commission. At the end of 1982, the Health Commission had achieved most of its foundational goals and was abolished to make way for a newly constituted Department of Health.

All psychiatric facilities built in the general hospitals of NSW after 1966, excluding the academic psychiatric units at Prince Henry Hospital and Westmead Hospital, were purpose-built to contain patients held under the Mental Health Act and were listed in the NSW Government Gazette as legally empowered to do so. (See List Two: General Hospital Psychiatric Units in Sydney). By the end of the financial year 1974-75 there were 220 psychiatric beds in the general hospitals that were supported by the NSW Government. In 1975 gazetted acute psychiatric units opened at Hornsby and Liverpool. In 1976, a gazetted acute psychiatric unit opened in Bankstown. Five new general hospital psychiatric units opened in 1977 and three in 1978. By June of 1979 there were 427 beds intended for short-stay psychiatric care in fourteen general hospital psychiatric units in NSW. Some of those 427 beds were intended for psychogeriatric patients requiring only short-term management. In 1979, there were still 855 beds intended for acute care purposes and 2,085 beds intended

for rehabilitation and chronic care and forensic purposes in the nine mental hospitals of NSW.¹³ A simple calculation shows that, in NSW, in June 1979, a third of the acute psychiatric admission beds were in general hospitals and two thirds of acute psychiatric admission beds were in the mental hospitals.

10.8 A cautionary tale for New South Wales, in 1977, concerning developments in psychiatric services in Britain

In 1977, a paper appeared in the *MJA* that expressed grave misgivings about developments in psychiatric services in the United Kingdom. This paper, written by Associate Professor Peter Burvill, from Western Australia, sketched recent developments in psychiatric services in England and Wales, and advised that Australian psychiatric services should learn from the mistakes that had been made in Britain.¹⁴ Burvill emphasized that, in 1977, British law allowed the involuntary admission of psychiatric patients into the general hospitals of England and Wales but in most Australian states such admissions were unlawful. Between 1962 and 1971 the British Government had adopted policies that all the psychiatric beds in the mental hospitals of England and Wales would be moved into general hospitals and that mental hospitals would eventually be phased out. In pursuit of these policies the psychiatric facilities that were being planned and constructed in the general hospitals that were scattered across England and Wales, and which were called district general hospitals, were intended to provide 'comprehensive services' to large populations of between 150,000 and 200,000 persons. Within these 'comprehensive services', clinical teams would each be totally responsible for the mental health needs of approximately 60,000 persons. The psychiatric facilities at these district general hospitals would each contain between 100 and 150 beds for inpatients and spaces for 50 to 100 day-patients.¹⁴

Burvill then recorded that his English colleagues made frequent complaints about the difficulties and limitations associated with the transformation of psychiatric services in England and Wales. It was proving exceedingly difficult for district general hospitals to find placement for patients who were elderly, who had chronic mental illness, or who had been in hospital more than twelve months and were becoming 'new long-stay patients'. These district general hospitals were also finding it difficult to manage certain other groups: patients who exhibited aggressive, antisocial or immature tendencies; patients who were drug dependent and patients who exhibited behaviours associated with epilepsy or other organic mental disorders.¹⁴

According to Burvill, British general hospitals that attempted to provide 'comprehensive services' were failing and were overflowing. The only general hospital services that seemed to be working were those which were backed up by a nearby mental hospital which could provide psychogeriatric, long-stay and various other specialised services.¹⁴ Burvill confidently predicted that there would always be a need for specialised psychiatric services that were not usually available in general hospitals. These included services for forensic patients and for patients with special problems, such as developmental disability and psychiatric disorders which occurred in adolescence.¹⁴

In stark contrast to the situation in Britain, in 1977 the Australian general hospitals that possessed psychiatric units were confined to a small number of major cities. These were usually academic units and they usually contained between 20 and 40 beds. Those units were not designed to hold patients involuntarily or to provide long-term patient care. Because the Australian general hospitals had far fewer psychiatric beds and much less space for ambulant

activities, they would have no leeway to deal with the problems that already beset the general hospitals of England and Wales.¹⁴

In his concluding paragraphs, Burvill stated that ‘... the question of general hospitals developing comprehensive general hospital psychiatric units had not arisen in Australia’.¹⁴ Burvill opined that those Australian general hospitals should not attempt to provide comprehensive services. He noted that many Australian general hospitals already provided 24-hour psychiatric emergency services, together with inpatient, outpatient and day-hospital services and some were starting to develop community services. He argued that the psychiatric services provided by Australian general hospitals should complement, rather than supplement the services provided by the mental hospitals. The services of general hospital psychiatric units should be incorporated in the overall plans for the mental health services of the various states. To ensure that there was optimal collaboration between general and mental hospitals there should be some joint appointment arrangements for senior staff.¹⁴ General hospitals should provide psychiatric services to a local catchment area but would work in close collaboration with mental hospitals. The latter would admit certain categories of acute patients, including certified patients, from that catchment area, and should provide facilities for medium-stay and long-stay patients, and for psychogeriatric patients. The mental hospitals should also provide space for special clinical units such as those for the management of forensic patients and for problems caused by alcohol misuse.¹⁴

10.9 Developments in psychiatric services in NSW in the 1980s and the 1990s

The rapid exodus of patients from the mental hospitals between 1962 and 1969 continued through the 1970s, leading to the removal of many beds and wards from the mental hospitals. In the late 1970s public concern was reported in the media regarding the number of mentally

ill persons wandering the streets, sleeping rough and, sometimes, ending up in prisons. Many mentally ill persons needed frequent readmission to psychiatric facilities, reflected in the expression ‘revolving door syndrome’. In some quarters it was alleged that idealistic but ultimately naïve attempts to implement ‘deinstitutionalisation’ had created a cohort of mentally ill persons who lacked adequate care and treatment.

In 1982, the Minister for Health in the Wran Labor Government of NSW, Mr Laurie Brereton, launched an inquiry into the availability of health services for psychiatrically ill and developmentally disabled persons in NSW.¹⁶ That inquiry was chaired by a public servant, Mr David Richmond, assisted by Dr Maurice Sainsbury, Director of the NSW Institute of Psychiatry, and by a representative of the trade unions. The Richmond Report, published in 1983, identified serious deficiencies in the provision of community mental health services and in the management of developmental disability throughout NSW. The Report offered several major recommendations, the first two of which were:

1. That services be delivered primarily on the basis of a system of integrated community-based networks, backed up by specialist hospital or other services as required.
2. That the two prime operational objectives be to (i) fund and/or provide services which maintain clients in their normal community environment; and (ii) progressively reduce the size and the number of existing Fifth Schedule hospitals by decentralising the services they provide.¹⁵

Another major recommendation of the Report was that services intended for persons who had psychiatric disorders and those intended for persons who had developmental disabilities should, as far as possible, be divorced from each other in their funding and in their administration. The Report also recommended that Area Boards should be created to take full

control of the management of the Second Schedule hospitals, the Fifth Schedule hospitals and the community services intended for the populations within the boundaries of geographic communities. The Report also recommended the enhancement of staffing for community mental health services and for psychiatric assessment services in general hospitals. Additionally, it recommended that recurrent funding for community psychiatric services be enhanced relative to the recurrent funding for other psychiatric services.¹⁵

In 1983 and again in 1988, the NSW Government instigated reviews of mental health legislation by steering committees chaired by Ms Anne Deveson. The advice of those committees contributed to the creation of community treatment orders (hereafter, CTOs) as a means of ensuring that mentally ill persons would remain in treatment while they were living outside hospitals.¹⁶ Provisions concerning CTOs were incorporated in a new Mental Health Act in 1990. The Act also created the Mental Health Review Tribunal. This quasi-judicial body, which consisted of lawyers, psychiatrists and community representatives, had the legal power to authorize CTOs and to periodically review the management of patients subject to them. If the management of patients was not proving to be effective, the Tribunal could adopt one of three options: it could discharge patients from involuntary treatment; it could insist on alterations in their treatment program; or it could determine that patients must be admitted to a psychiatric facility for involuntary management. The creation and the functioning of the Mental Health Review Tribunal and the implementation of CTOs led to improvements in the management of psychiatric disorders in community settings. However, it was never expected that these measures would totally eradicate the problems of homelessness, lack of physical and mental security and lack of social and emotional support that threatened the mental ease and the welfare of persons who had serious mental illness.

10.10 National Action on Mental Health: The First National Mental Health Plan (1992) and the policies of ‘mainstreaming’ and ‘integration’

Pressure for the creation of a national approach to mental health issues grew throughout the 1980s, and, in 1990, the Commonwealth Government established a National Inquiry into the Human Rights of People with Mental Illness, otherwise known as the Burdekin Inquiry.¹⁷ For three years the Inquiry focussed public attention on deficiencies in mental health services throughout Australia. In April of 1991, a meeting of the health ministers of all the Australian jurisdictions, labelled the Australian Health Ministers Conference (AHMC), agreed to the creation of a collaborative framework that would engage all levels of government in addressing issues affecting psychiatric services throughout Australia. In 1991, the AHMC endorsed a National Mental Health Policy, a National Mental Health Plan and a Mental Health Statement of Rights and Responsibilities, all of which would be reviewed after the passage of five years.¹⁸ The interpretation of a particular clause of the Mental Health Statement, that ‘priority should be given to those with severe mental health problems and mental disorders,’ gave rise to disputes between the clinical subgroups within the mental health professions.¹⁹ Community-focussed mental health subgroups interpreted this statement as assigning priority to their work over that of other subgroups, including the consultation-liaison subgroup. The trouble that stemmed from this interpretation is discussed in *Chapter Twelve: The birth and growth of consultation-liaison psychiatry in New South Wales*.

The First National Mental Health Plan (1993-1998) pledged nationwide commitment to policies of ‘mainstreaming’ and of ‘integration.’¹⁸ It defined these policies in the following way:

Mainstreaming refers to the process of moving psychiatric services into the mainstream of general health; in particular, co-locating psychiatric units within general hospitals.

Integration refers to the coordination of hospital and community components of a mental health service so that together they provide a seamless continuity of care.¹⁸

The Plan expressed commitment to deinstitutionalization but it is important to note that unlike the policy adopted in England and Wales, there was no stipulation that stand-alone mental hospitals must be abolished.

10.11 Mainstreaming and integration of psychiatric services in New South Wales: 1991-1994

In its own strategic plan for mental health services, which the NSW Government labelled *Leading the Way: A framework for New South Wales Mental Health Services (1991-2001)*, it endorsed the national policies of ‘mainstreaming’ and ‘integration’.²⁰ The *Leading the Way* strategic plan emphasized ‘integration’ and the need for continuity of management of patients as they moved between inpatient care and residence in their communities.²⁰ In 1992 the gazetted bed capacity of the 21 general hospital psychiatric units of NSW was 553. The total gazetted bed capacity of the mental hospitals had fallen to 2,087.²¹ (See List Two: Major Mental Hospitals in New South Wales). The migration of acute psychiatric services from the mental hospitals to the general hospitals proceeded steadily throughout the 1990s. In 1993, after the last of its inpatients had been moved to Macquarie Hospital at North Ryde, Gladesville Mental Hospital was decommissioned. In 1994 there were seven stand-alone mental hospitals in NSW. Their patient numbers were less than half of that of mental

hospitals in 1898, reducing from 3,922 in 1898 to 1,701 in 1994.²² On 30th June 1994, 1,364 patients were resident in mental hospitals and 95 patients were on leave.²² The occupancy of those mental hospitals was therefore about 80%, a standard which most mental health experts would regard as clinically acceptable.

During 1994 there were 8,143 admissions to the mental hospitals of NSW.²² These accounted for 44% of all admissions to public psychiatric beds in the State during the financial year 1993-1994. The length of stay of patients in acute admission wards of mental hospitals was like that of general hospitals: between 14 and 21 days. Greater contrast was to be found in the average duration of stay of patients in mental hospitals. Here, patients averaged more than 150 days of inpatient care. Most of the beds in the mental hospitals were occupied by patients who were participating in rehabilitation programs, were chronically mentally ill or were forensic patients. Patients who were brain damaged or who were recovering from severe or protracted mental illnesses, such as chronic schizophrenia, might require many months of rehabilitation in inpatient settings. Rehabilitation programs were designed to re-educate patients, over a period of weeks or months rather than of days, to the point that they might return to their communities as well as to the workforce and then participate in social interactions with some degree of ease. In 1994, some mental hospitals provided special programs for the rehabilitation of persons recovering from episodes of drug and alcohol misuse. It was possible to stay as an inpatient for much longer in mental hospitals than in general hospitals because there was less pressure, in mental hospitals, to create vacancies to allow new admissions.

*

List Two: Major mental hospitals in New South Wales

	<u>Opened</u>	<u>Closed</u>
1. Gladesville	1838	1993

2. Parramatta (Cumberland Hospital)	1848	#
3. Newcastle (Watt Street)	1871	2009
4. Callan Park	1878	2008
5. Rydalmere	1888	1986
6. Kenmore	1895	2003
7. Morisset	1909	#
8. Stockton – DD	1917	1989
9. Peat & Milson Is – DD	1910 & 1920	1973
10. Bloomfield	1925	#
11. North Ryde (Macquarie Hospital)	1959	#

Notes: In 2022, all four hospitals marked by a dash [#] retain wards for rehabilitation and other medium and long-term purposes. North Ryde/Macquarie and Parramatta/Cumberland Hospitals retain admission centres and admit new patients. The admission wards at Morisset and Bloomfield Hospitals were closed, respectively, in 1985 and 2011.

DD: Developmental Disabilities: Stockton Hospital and Peat and Milson Islands were used exclusively to accommodate persons who had developmental disabilities.

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By 1994, large numbers of the developmentally delayed persons who previously resided in the mental hospitals of NSW had been discharged and were no longer subject to the provisions of the Mental Health Act. Commencing in 1987 the first Guardianship Act of New South Wales clarified and enhanced the guardianship powers of family members or other persons who the Guardianship Tribunal judged to be well-motivated and competent to supervise accommodation, clinical care and other aspects of the daily lives of developmentally delayed persons. In circumstances where no one was available to perform those duties, the Public Guardian of New South Wales could take up those responsibilities.

After 1843, criminally insane persons—later known as forensic patients—were managed in one or more of the mental hospitals of NSW. In 1994, they were housed in special wards at Morisset Hospital, Bloomfield Hospital (at Orange) and at Cumberland Hospital (at North Parramatta). A large (135 bed) forensic psychiatric hospital was planned to open in 2008 within the Long Bay Correctional Complex to provide much higher security than was possible, or desirable, in mental hospitals. The remaining clinical functions of the Rozelle

Psychiatric Hospital were destined for relocation to a new mental health precinct within the grounds of the Concord General Hospital in 2008 and Rozelle Hospital would then be decommissioned. However, in 1994, it was safe to predict that, for many decades, the NSW Government would be forced to maintain several large stand-alone mental hospitals for the management of certain groups of chronically mentally ill and forensic patients.

10.12 The consequences of the existence of many voluntary-admission psychiatric beds in the public general hospitals of NSW between 1965 and 1994

In 1965 six general hospitals in Sydney contained general hospital psychiatric units. Between them, those units contained more than 200 beds, none of which were gazetted and none of which were reserved for the use of patients from delineated catchment areas (See List One: General Hospital Psychiatric Units in Sydney). Those ‘voluntary-admission’ beds were maintained and funded by the Government of New South Wales and, in the case of Concord Hospital, by the Commonwealth Government. Those beds were the clinical responsibility of the departments of psychiatry at each of those general hospitals. Each of those departments of psychiatry were keen to establish excellent consultation-liaison services. Between 1965 and 1994, hosts of trainee psychiatrists received much of their training towards Fellowship of the RANZCP in those general hospitals. Between 1976 and 1994, all the ‘voluntary’ psychiatric beds in those hospitals were destined for removal as each of those facilities were rebuilt and gazetted so that each hospital could manage patients who were detained under the Mental Health Act. The very existence of those ‘voluntary’ psychiatric facilities, for more than two decades, would have a significant impact on the training of psychiatrists and on the shape of psychiatric services in NSW for decades after 1994. The legacy of that episode in the history of general hospital psychiatry in NSW will be examined in *Chapter Twelve: The birth and growth of consultation-liaison psychiatry in New South Wales*.

Between 1976 and 1994, five of the six ‘voluntary-admission’ general hospital psychiatric facilities that were supported by the NSW Government were radically rebuilt and gazetted. In 1977, after its patients and staff had been relocated to a new fully gazetted academic psychiatric facility at the Prince of Wales Hospital, the sixth of those facilities—the Prince Henry Hospital—was decommissioned. The Caritas Centre at St. Vincent’s Hospital was rebuilt and gazetted in 1976. (See List One: Psychiatric Units in General Hospitals in Sydney). This was followed by the rebuilding and gazettal of the Cummins Unit at Royal North Shore Hospital in 1983 and of Pacific House at St George Hospital in 1986. Therefore, in 1990, there were only two general hospitals supported by the Government of New South Wales which retained ‘voluntary’ psychiatric beds. These were the academic psychiatric units at RPA Hospital and Westmead Hospital. In January 1993, the psychiatric facility at RPAH was gazetted. During rebuilding, which took three years, and during which the staff and patients were accommodated at Rozelle Psychiatric Hospital, the footprint of the Psychiatry and Neurosurgery Pavilion was extended to provide an additional ten-bed highly secure ward called the Acute Observation Area. The Acute Observation Area had a special entrance to securely allow the admission of patients who had been transported by the ambulance service or escorted by police. Following these and other major structural changes, the ground floor of the Psychiatry and Neurosurgery Pavilion was able to accommodate a total of forty inpatients in a facility that was sufficiently secure to permit the safe management of involuntary patients. The pre-existing thirty beds had been reconfigured to permit better security and better placed nursing observation stations than prior to 1993. There were more double and single bedrooms than previously. Four or five of the forty beds were reserved for patients who had eating disorders (Professor Beaumont’s clinical and research interest). A small area was designed for the management of mothers and their babies. Additional rooms were

constructed on the second level of the building for hearings by magistrates. Advanced technology was installed on the second level which would permit clinical and legal reviews to be conducted by video-link. When it reopened in the middle of 1996, the Missenden Inpatient Unit did so as a totally gazetted psychiatric acute admission centre with responsibility for the mental health needs of adults under the age of 65 who resided in clearly demarcated geographic communities. However, four or five of the forty gazetted beds were intended for patients who had eating disorders. There was no requirement that patients admitted to those eating disorders beds should reside within the catchment area of the RPA psychiatric service. In 1996 it was still unclear how patients who needed prolonged care would be managed but there was a presumption that some 'back-up' would be provided by one of the remaining mental hospitals.

On the 5th of August 1994, the last of the psychiatric beds at the Westmead Hospital were gazetted. In 2010 total responsibility for Concord Hospital was destined to be transferred from the Commonwealth Government to the State Government of NSW. All the psychiatric beds at Concord Hospital would then be gazetted and Concord Hospital would become responsible for the mental health needs of adult persons within a well delineated catchment area.

10.13 The relevance of the private practice of psychiatry to general hospital psychiatry in New South Wales

In earlier chapters of this dissertation, it was noted that private general hospitals, private psychiatric hospitals, private psychiatric practice, and private health insurance were far more relevant to the developmental history of general hospital psychiatry in the United States than in the United Kingdom. In the paragraphs which follow, the relevance of the private practice

of psychiatry, and private medical insurance to the development of general hospital psychiatry in New South Wales will be examined.

After 1900, private hospitals occupied an increasingly important place in the general health services of NSW. The Sanitarium Hospital at Wahroonga opened in 1903 as a private general hospital and grew without any direct government support. As the century progressed, several significant private general hospitals were built. These were usually adjacent to large general hospitals. In Sydney, the best known of these hospitals were St. Vincent's Private Hospital and the Royal North Shore Private Hospital. None of the private general hospitals in NSW have ever allocated beds for the care of psychiatric patients and none have ever contained gazetted psychiatric beds. Therefore, private general hospitals have never played a significant role in the history of general hospital psychiatry in NSW.

The first privately owned mental hospital in NSW was the licensed private asylum, sometimes called Bayview House, which overlooked Cooks River to the south of Sydney. It functioned between 1865 and 1946. Bayview House was, ostensibly, for the management of private patients but most of its inmates were certified patients who had been transferred from the public mental hospitals and whose management was financed by the NSW Department of Lunacy. Those patients were invariably placid and well-behaved persons who did not pose security risks. In 1882 there were 144 certified patients in Bayview House, all but seven of whom were female. The number of patients in private psychiatric hospitals in New South Wales steadily increased during the first half of the twentieth century. In 1955, there were nearly two hundred beds in private psychiatric hospitals in NSW. That year, close to half of those beds were occupied by patients who had developmental disabilities or who had problems related to the abuse of alcohol. In 1955 the only private hospital in NSW which was

licensed to hold patients under the Mental Health Act of 1898 was the Mount Saint Margaret Hospital, which held seventy-three certified patients and eighty-one voluntary patients.²³ Since 1958, and the passage of a new Mental Health Act, none of the private psychiatric hospitals in NSW have contained beds that were gazetted to hold patients involuntarily. Beds in private psychiatric hospitals in NSW more than doubled between 1958 and 1988. In the latter year, across Australia, about twelve percent of psychiatric beds were in private psychiatric hospitals.²⁴ In the same year, in NSW, there were 388 beds in six licensed psychiatric hospitals.²⁵ However, because none of those beds were gazetted, it is safe to conclude that none of those private psychiatric hospitals managed patients who were severely disruptive or severely suicidal. However, it would be wrong to conclude that the role of private psychiatric hospitals in the management of mental disorders in NSW has been insignificant. Private psychiatric hospitals have played an important role in the management of certain mood disorders, eating disorders, substance abuse disorders and non-violent personality disorders. Research by Gavin Andrews in the late 1980s and early 1990s suggested that the contribution to the management of mental disorders in Australia by private practitioners of psychiatry has been substantial and that the importance of private practice to the mental health services of Australia deserves more systematised research.^{24,26}

Between the 1920s and the 1970s an unknown, but probably significant proportion of the psychiatrists who worked in private practice in New South Wales, maintained unpaid honorary positions at general hospitals. Their services were mostly confined to the outpatient clinics. In 1955 there were still only sixteen psychiatrists in full time private practice in NSW.²⁷ Their numbers increased steadily during the 1960s. During that decade, private practitioners were among the many consultant psychiatrists who were appointed to the new general hospital psychiatric units which appeared in Sydney. Many of those private

practitioners accepted liaison psychiatric attachments to work in the non-psychiatric wards of those hospitals. In the 1970s many of them surrendered honorary status in favour of contracts for sessional attendance as Visiting Medical Officers (VMOs). However, some honorary psychiatrists and VMOs were disappointed or annoyed when all the beds in the general hospital psychiatric units became gazetted because gazettal quickly led to full occupancy of those beds by patients held under the Mental Health Act and it became almost impossible for honorary consultant psychiatrists or VMOs to find empty beds for the admission of their own private patients.

A decision, in 1973, by the (Commonwealth) Ludeke Medical Fee Tribunal concerning consultation fees, together with the introduction of universal health insurance in 1975 by the Whitlam Government, led to rapid growth in the private practice of psychiatry throughout Australia. In the late 1970s trainee psychiatrists, more than half of whom would eventually enter private practice, were acutely aware that they needed access to excellent training in the assessment and the management of patients who had medical and psychiatric comorbidity and of patients who had somatoform disorders. Those trainees were vocal advocates for the retention of six months of supervision and experience in consultation-liaison psychiatry as a prerequisite for entry to Fellowship of the RANZCP.²⁸ In 1989, fifty-five percent of Australian psychiatrists who responded to a survey by Gavin Andrews recorded that they worked mainly in private practice.²⁴

The Commonwealth Health Insurance Commission (Medicare), which was established in 1975, reimbursed eighty-five percent of a standardised fee paid to psychiatrists in private practice if those psychiatrists were formally accredited as 'consultant psychiatrists.'²⁹ The Health Insurance Commission accepts Fellowship of the Royal Australian and New Zealand

College of Psychiatrists (RANZCP) as the standard qualification for accreditation as a ‘consultant psychiatrist.’ It follows that one of the most important functions of the RANZCP has always been to ensure that all the Fellows of the RANZCP were competent to practice as ‘consultant psychiatrists.’ Fortunately for Australian consultation-liaison psychiatrists, the RANZCP has always strongly supported the existence and the growth of their subspecialty.

10.14 The role of general practitioners in the management of psychiatric disorders in New South Wales

Throughout the twentieth century the role of general practitioners in the management of psychiatric disorders has steadily increased. Since 1960 that role has grown more rapidly and has become better defined. In 1991, Australian GPs were treating approximately forty percent of those persons who sought attention for mental health problems.³⁰ In 1992 the National Mental Health Policy recognised and emphasized the place of general practitioners in the management of mental disorders. That Policy acknowledged that general practitioners were the first point of help-seeking for most Australians who had mental health problems. In its *Leading the Way (1991-1994) Strategic Plan*, the NSW Government acknowledged that GPs were the mainstays of psychiatric care for most of the population of New South Wales.²⁰ The NSW Government assumed that GPs could always rely on access to the advice, and the collaboration, of mental health professionals who worked in community health services, in private practice, and in the general hospitals and mental hospitals.

10.15 Community mental health services in New South Wales

In the first decades of the twentieth century, in the minds of most citizens of NSW, the concept of insanity—severe mental illness—was automatically linked to certification and committal to a mental hospital. In those years, concepts like preventive psychiatry and

community psychiatry would have seemed very strange. Between 1900 and 1960, the main reason why psychiatrists wished to introduce some acute psychiatric services into the general hospitals was their wish to make it easy for people who had incipient mental disorders to obtain rapid assessment and management of their mental problems and to avoid certification to mental hospitals and other restrictive procedures. Psychiatrists hoped that the early treatment of incipient insanity would prevent overt insanity or cut short its duration. The other principal reasons for locating some acute psychiatric assessment and treatment services in general hospitals were to improve the education of health professionals in the diagnosis and management of psychiatric disorders and to bring the specialty of psychiatry closer to the centre of general medicine. (See *Chapter Six: New proposals for a new century.*)

In the late 1950s, the newly minted advocates for preventive and community psychiatry provided a fourth argument that favoured the creation of psychiatric units in general hospitals. They contended that general hospitals were far preferable to mental hospitals as places for the assessment and management of mental disorders because they were less associated with stigma than the mental hospitals and because they were more numerous and closer than mental hospitals to the homes of the clientele which psychiatry should serve. Yet, in 1955, the only significant government-funded mental health services to be found outside the walls of the mental hospitals of New South Wales were the inpatient services at RPA Hospital and Concord Repatriation Hospital and the outpatient psychiatric clinics at many of the other major general hospitals.

No detailed and comprehensive account of the evolution of community mental health services in NSW has been published but there is anecdotal evidence that a community service existed in the 1960s in the Municipality of Canterbury that was associated with Broughton

Hall Special Hospital. However, it is documented that a community psychiatric service was established during the mid to late 1960s at Eastwood and another at Lane Cove, on the lower North Shore of Sydney by staff of the North Ryde Psychiatric Centre.³¹

In January 1972, the Minister for Health for New South Wales, Mr Harry Jago, announced that RPA Hospital would set up what was claimed to be Australia's first community health care unit '... to help general practitioners treat people who do not really need to be admitted to hospital.'³² This community clinic was linked to Sydney University's Department of Community Medicine. In December 1972, a diverse group of health professionals commenced clinical activities in rooms which had belonged to the Glebe Annex of the Balmain Hospital and the Glebe Homeopathic Hospital. Those clinicians were drawn from the existing staffing of three institutions: from RPA Hospital, from the Sydney Home Nursing Service and from the Rozelle Psychiatric Hospital. The last-mentioned provided the Centre's first mental health professionals: two mental health nurses and a part-time psychiatrist. In 1973 additional mental health personnel, including a full-time psychiatrist, were seconded from the Psychiatry Department at RPAH.³² In April 1975 the Newtown Community Care Centre commenced operations three kilometers to the south of the Glebe Community Centre. For administrative, training and teaching purposes the Newtown Community Care Centre was closely linked with the Glebe Community Care Centre; both centres functioned under the auspices of the Department of Community Medicine of the University of Sydney.³³ The Annual Report of the Health Commission of NSW for 1976 recorded that the relationship between the Department of Psychiatry at RPA Hospital and nearby community psychiatric services had been restructured in conformity with the plans for regional psychiatric services.³⁴ In 1977 the Annual Report of the Health Commission recorded that '...the Professional [*sic*] Psychiatry Unit at the Royal Prince Alfred Hospital

has enlarged its area to serve the Glebe area through the Glebe Community Care Centre.’³⁵

The Redfern Community Health Centre was less than four kilometers to the east of the Newtown Centre and provided mental health services to the residents of the municipalities of Redfern, Pyrmont and Ultimo. It had been created and staffed, a decade earlier, by the Department of Psychiatry of the Prince of Wales Hospital, which was situated in the Eastern Suburbs. In the 1980s, total responsibility for the Redfern Community Health Centre, including its staffing, was transferred to the Central Sydney Area Health Service and the catchment area of the Redfern Centre became linked to RPA Hospital.

During the 1970s and the 1980s, community mental health services were established throughout New South Wales. It should be noted that the advocates for community-focused psychiatric services have repeatedly complained that the degree of support for community mental health services provided by the NSW Government has always been inadequate and inferior to the support provided to community mental health services by other Australian state governments. The same protagonists of community psychiatry have also accused the NSW Government of failing to channel sufficient resources towards community mental health services relative to those which it provided for inpatient services in the mental hospitals and in the general hospitals of New South Wales.^{36,37}

10.16 Conclusions

In the late 1950s and early 1960s there was a dramatic renaissance in psychiatric services in the world’s industrially advanced countries, but there were variations in the pace and in the details of those metamorphoses. In earlier chapters of this dissertation, it was noted that the psychiatric services of NSW developed according to a British template until 1948 but then followed a pathway that was less dependent on British influence. After 1948, local medico-

legal considerations and the Australian federal system of government permitted and sometimes encouraged the evolution of private practice, psychodynamic ideas and practices and attention to a broader spectrum of psychiatric disorders than was possible in Britain. In the post-war decade Australian psychiatry became increasingly exposed to influences from the United States.

In New South Wales, between 1956 and 1962, the psychiatrist who likely had the greatest influence on psychiatric services was Bill Trethowan, an English psychiatrist who had undertaken a brief period of post-graduate study at the Massachusetts General Hospital. After 1961, the psychiatrists who exerted the greatest influence on the psychiatric services of NSW were probably the Australian-born, Bill Barclay and David Maddison. A significant influence from neighbouring Victoria, was Eric Cunningham Dax, who had migrated from Britain in 1951. Perhaps more important than the birthplace, or the initial psychiatric training of these leaders of the psychiatric profession was the individual character, the vitality and the creativity of each of them. The career of David Maddison, and of another important academic psychiatrist, Issy Pilowsky, both of whom influenced the shape of psychiatric services in NSW, and both of whom had some impact on general medicine in NSW, will be described and discussed in *Chapter Eleven* of this dissertation. Questions about the trajectory of psychiatric services in the general hospitals of NSW will also be addressed in *Chapter Twelve* and *Chapter Thirteen*.

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Chapter Eleven

The Impact of Psychiatry on General Medicine: David Maddison and Issy Pilowsky

11.1 Introduction

This chapter describes and contextualises the contributions of David Maddison and Issy Pilowsky to the development of general hospital psychiatry in New South Wales and elsewhere. In the early 1960s, these two academic psychiatrists who worked together at the University of Sydney, at RPA Hospital and at Broughton Hall Special Hospital shared the conviction that psychiatry had much to contribute to general medicine. They differed greatly in their personalities, professional styles and short-term goals and their professional pathways were about to diverge. Each was destined to have a significant influence on the future of psychiatric education and psychiatric services and on the place of psychiatry within general medicine in New South Wales and in other parts of Australasia.

11.2 Might psychiatry provide a favourable influence on general medicine?

In 1934, the third Inspector-General of Mental Hospitals for NSW, Dr Charlie Hogg, repeated the claims that had been made by psychiatrists during professional meetings in 1902 in Edinburgh, Liverpool and in Melbourne, and which were described in *Chapter Six* of this dissertation, that many aspects of psychiatric education and practice would benefit if psychiatry could find a place in the general hospitals.¹⁻³ It is noteworthy that neither Hogg, nor the speakers at those much earlier meetings, claimed that the general hospitals or general medicine had anything to gain from the introduction of psychiatry into their midst. In the same decade as Hogg, but in the United States, Dr Alan Gregg, the director of the newly

constituted Medical Sciences Division of the Rockefeller Foundation was just as intent as Hogg on fostering the growth of psychiatry and encouraging its acceptance as a medical specialty, but Gregg had an additional, and far more radical ambition. Gregg's career and his ideas are discussed in *Chapter One* and in *Chapter Twelve* of this dissertation. Suffice to say here that Gregg was convinced that general medicine would be a major beneficiary if psychiatry entered the general hospitals.⁴ In a review of Gregg's professional goals and achievements, published in 1987, the American psychiatrists, Summergrad and Hackett, opined that:

The debates in the 1930s about psychiatry and its role in the general hospital heralded contemporary concerns. Those who saw psychiatry as a force for the reform of medical practice and education also saw it not only leaving the asylum, but the care of specific illnesses as well. With his support for the scientific, especially neurobiological, study of psychiatric illness qua illness, Gregg would be easily recognised by his many modern counterparts.⁴

Two of Gregg's 'modern counterparts' in the 1960s were David Maddison and Issy Pilowsky. Throughout their careers, each tried to broaden the scope of clinical psychiatry and each attempted to bring psychiatric insights and attitudes into clinical medicine, into medical education and into medical research. They did so by very different methods and with differing styles of interaction with their colleagues. Maddison focussed his energies on medical education, on the governance of psychiatry and on the governance of general medicine. Pilowsky focussed his energies on research in the borderland between medicine and psychiatry and on the education of the medical profession in the tenets of consultation-liaison psychiatry.

11.3 David Clarkson Maddison

Maddison was born in Sydney in 1927. After qualifying in medicine at the University of Sydney and at RPAH, he trained, from 1950 to 1953, as a medical officer in the mental health service of NSW. Between 1954 and 1956, he was a consultant psychiatrist at Broughton Hall Special Hospital—with an interval of twelve month's leave to study with Dr Denis Hill at the Middlesex Hospital in London. In 1957, Maddison joined the University of Sydney as a Senior Lecturer in the Department of Psychiatry. In 1962, he succeeded Bill Trethowan as Chair of Psychiatry and became the first locally born professor of psychiatry in Australasia.⁵ It was noted in *Chapter Ten* that, in 1962, David Maddison took the place that had been vacated by Professor Bill Trethowan on the New South Wales Health Advisory Council (1961 to 1973). In that chapter it was explained that the Health Advisory Council played a crucial role in guiding the restructuring of the mental health services of NSW that occurred after 1961, with profound consequences for general hospital psychiatry and community psychiatry. In 1964-65 Maddison took sabbatical leave to study preventive psychiatry in Boston with Gerald Caplan. At this time, Caplan was recognised as the leading international authority on the theory and practice of 'preventive psychiatry', a term which was then employed to connote what is now more often known as 'community psychiatry'.

Between 1961 and 1971, Maddison was the Chief Censor of the fledgling Royal Australian and New Zealand College of Psychiatrists, and later, in 1974 and 1975, served as its President. In both roles he supported a rigorous educational program for trainee psychiatrists and established demanding criteria for entrance into Membership and Fellowship of the College. As the Chair of Psychiatry at the University of Sydney he revamped the undergraduate training program in his school. Then, as sub-Dean and as Dean of the Faculty of Medicine, he restructured the medical undergraduate training program in favour of his own educational philosophies. He attracted to the Department of Psychiatry at the University of

Sydney, and to RPAH, a group of young psychiatrists who would have significant careers in academic psychiatry. They included Ross Kalucy, Beverley Raphael, Bob Adler and Bruce Singh. Each adopted important elements of Maddison's psychiatric philosophies and psychiatric attitudes.

In a presentation in 1981, published as a paper titled: 'Psychiatry's Liaison with Medicine: Bride or Mistress?' Maddison acknowledged his indebtedness to Denis Hill in London and to George Engel in Rochester, New York, for their insights concerning the ideal relationship between psychiatry and medicine. Concerning George Engel, Maddison commented:

He has been a potent force in helping us to realise that the cross-fertilisation process is indeed a two-way process—for not only does medicine have an inescapable contribution to make to psychiatry, but psychiatry has an equally inescapable, and **perhaps even more beneficial contribution** to make to medicine.⁶ [Present author's emphasis]

Towards the end of that presentation Maddison added:

What we must bring to medicine—what we have already brought to medicine in generous measure—derives from our increasing sophistication in the understanding of intrapsychic processes, heightened awareness of the social determinants of behaviour, and our sensitivity to the nuances of cultural influences.⁶

In 1975, shortly after his appointment as Dean of Medicine at Newcastle, Maddison delivered the Beattie-Smith Lecture at the University of Melbourne. His lecture, which exemplified Maddison's educational philosophies and professional values, was later published in two parts in the *Medical Journal of Australia* as 'A Psychiatrist in the Dean's Office'.^{7,8} Here

Maddison claimed that psychiatrists had already shown their worth as deans of medical schools and instanced the recent achievements of Professors Bill Trethowan and William Cramond. Maddison insisted that medical education needed a major overhaul. He listed and described three special attributes that psychiatrists could bring to medical education. These were ‘The Psychiatrist’s Attitudes’, ‘The Psychiatrist’s Knowledge’ and ‘The Psychiatrist’s Skills’. Of these attributes, Maddison prioritised ‘The Psychiatrist’s Attitudes’ and proposed that attitudes should receive far more attention in the processes of medical education than had previously been the case, noting:

One of the most serious criticisms that one can make of medical education in recent times is that it has been concerned above all other things with the transmission of knowledge, relatively little with teaching the appropriate skills and hardly at all with the attitudes of its students and the ways in which they are affected, commonly I fear for the worse, by the educational process.⁷

‘The Psychiatrist’s Attitudes’

Under the heading ‘The Psychiatrist’s Attitudes,’ Maddison described the attitudes that should be encouraged during the education of medical students and doctors. The first of these attitudes was ‘caring’.⁹ Maddison claimed that many medical educators encouraged students to maintain emotional indifference towards patients. He noted that some medical schools, especially in North America, were beginning to reverse that process in favour of an attitude of caring.⁹ Maddison then proposed that medical educators should encourage self-awareness, and ‘...ensure that the student gradually develops an increasing awareness of himself—his own abilities, his limitations, his emotional responsiveness and the ways in which these affect his diagnostic and therapeutic decisions.’ Quoting Sir Denis Hill, Maddison argued that a medical student must learn:

... the role of his own personality in the doctor-patient relationship and how his own anxiety and prejudices may affect the way he handles patients and how they react to him. If one of the purposes of education is to enlarge the student's awareness of human reality and so increase his capacity for control of it, then for all doctors these matters are fundamental.⁹

In Maddison's view, psychiatrists, as educators, were in the vanguard of those who sought to introduce behavioural sciences into the medical curriculum. Maddison argued that the undergraduate medical curriculum should include a larger component of formal education in the social sciences to provide students with a more rigorous understanding of mankind, society and culture. Maddison acknowledged that this expansion of fields could limit space available in any curriculum for teaching the natural sciences. He added, here, that as long as such courses were 'not unduly restricted,' such a compression could be made without compromising student's scientific training. Maddison quoted Sir Martin Roth in stating that, while there were undeniable scientific benefits to be found in quantification and controlled experiment, it was also true that, at some stages in the development of certain fields of knowledge, both could only be employed to a limited extent. As long as medicine involved disinterested collection and verification of observations, it was under no threat of losing its claim to scientific legitimacy.¹⁰ Maddison then argued in support of his own prioritisation of behavioural sciences in the curriculum; he quoted George Engel to the effect that medical schools had not, heretofore, given sufficient attention to identifying and teaching the sciences basic to the clinical task of the physician.¹¹ Maddison then paraphrased Engel by proposing that the training curriculum ought focus on

... the elements of medicine—those aspects of medicine that are virtually timeless and unchanging ... the nature of the human encounter between patient and physician ... clinical observation ... clinical reasoning ... the processes of

clinical judgement and decision making ... Two things are immutable. One is that the physician must be qualified to use the scientific method in his work with patients, and the other is that he must be effective and skilful in eliciting clinical data and applying his knowledge for the benefit of the patient.¹²

Maddison abhorred the term 'history-taking' which he declared to be 'obnoxious' because of its mechanistic and extractive implications.¹² According to Maddison, if doctors lacked a psychiatrist's attitude, they would fail to gain the information required for an accurate diagnosis of the patient's condition. Psychiatrist-educators were well placed, by their training and experience, to foster the attainment of those skills. Maddison implied that, until medical students acquired those skills, they should not be allowed to graduate. Quoting the Dean of the Albert Einstein School of Medicine, Maddison added that psychiatrists were becoming the principal custodians of humanistic aspects of patient care in general hospitals and that they encouraged those values in medical students.¹³ Maddison proposed that, by nature of their training and experience, psychiatrists were better equipped to serve as deans of medical schools than other physicians, and that their technical legerdemain was uniquely suited to understanding the emotional stresses and conflicts confronting undergraduates. The prevalence of problems of suicide and of drug and alcohol abuse were known to be elevated in medical students and in the medical profession. It was important, then, that deans of medical schools should share the insights of psychiatrists concerning these ever-present hazards.⁷

'The Psychiatrist's Knowledge'

Under the major heading 'The Psychiatrist's Knowledge', Maddison described the second advantage of psychiatrists as deans of medical schools: they were more 'realistic' than other

doctors.⁸ In daily clinical practice psychiatrists witnessed the kinds of self-deceptions that limit an individual's management of physical and mental health. Consequently, psychiatrists were attuned to all types of self-deceptions, including those common within the medical profession. By nature of the kinds of illnesses to which they tended, psychiatrists were more aware of the limits of medicine. Not only were psychiatrists more practiced recognising and acknowledging the intractability of chronic illnesses, they were also less physician-centred and less hospital-centred than other kinds of doctors.

Maddison insisted that doctors must become familiar with psychodynamic principles. For Maddison, the good physician was one who was familiar with transference and countertransference distortions. The 'good physician' appreciated how the patient's ego-defences contributed to masochistic behaviour or to extremes of illness denial. Psychiatrists were also attuned to the importance of family factors, environmental issues, social network factors and social structures in the determination of many aspects of health-related and illness-related behaviour. As educators, then, psychiatrists were more likely to insist that these concepts be given their appropriate emphasis in any educational program.^{7,8} Maddison understood the psychiatrist to be an '...applied behavioural scientist, and it is thus natural for him to feel some affinity with that special category of behavioural scientists known as educators...'⁸

'The Psychiatrist's Skills'

Maddison discussed the third category of helpful attributes of psychiatrist-educators under the heading of 'The Psychiatrist's Skills'. Maddison argued that the clinical training and experience of psychiatrists underpinned their ability to work effectively as members of professional teams, as good collaborators in medical research, and to function well as

administrators.⁸ In the closing minutes of his lecture, Maddison described a scenario that may have had some commonality with the one that he had experienced as the Dean of Medicine at the University of Sydney.⁸

If and when it looks as though he [the psychiatrist-dean] is undermining the traditional medical school mythology, however carefully and gently, there may be a rapid closing of ranks against him, for there are a few physicians and medical educators who seem to spend their lives far more on cherished illusions than on the realities of learning and of clinical practice. In some quarters he runs the risk of being lynched if he focuses too heavily on the personality, the motivations and the problems of the doctor himself, particularly if the doctor's role is perceived as being downgraded in the process.⁸

In the Australian Dictionary of Biography and on the topic of Maddison's departure from the University of Sydney, Stephen Garton writes:

Though the pace for reform was by most measures respectable, Maddison was impatient for further progress. The University of Sydney was a large and complex organisation and sections of the faculty resisted change. In 1973 the Commonwealth government decided to establish a medical school at the University of Newcastle and Maddison, foundation dean from 1973, said that he found 'pretty irresistible the opportunity to start something from the beginning'.²

At the University of Newcastle, Maddison had a free hand to test out many of his ideas and to establish an innovative undergraduate curriculum. This opportunity came to a premature end. In 1981, David Maddison, who was a heavy smoker, died of a myocardial infarction at the relatively young age of sixty-four.

11.4 Issy Pilowsky

Dr Issy Pilowsky received his undergraduate medical training in Cape Town, where he submitted an MD thesis on hypochondriasis. Pilowsky, who was eight years younger than Maddison, graduated in 1956 and moved to the UK in 1959 to undertake postgraduate studies. At the University of Sheffield, working in the Department of Erwin Stengel, Pilowsky pursued his interest in hypochondriasis, in psychogenic pain and in conversion disorders. In 1966, he migrated to Australia to join Maddison's Department at the University of Sydney. Pilowsky took up clinical attachments at Broughton Hall Special Hospital and at RPAH. At the latter, he provided liaison services to the Department of Renal Medicine. In 1969, Maddison and Pilowsky co-edited a book on community psychiatry.¹⁴ They would, throughout their subsequent careers, also share a strong interest in the nexus between psychiatry and general medicine.

Like Maddison, Pilowsky was powerfully influenced by the ideas of George Engel. He took sabbatical leave to visit Rochester, New York, to study Engel's biopsychosocial approach to illness. It is interesting to consider the extent to which Pilowsky differed from Maddison in his personal interactions and in his professional style. Within psychiatric and medical organisations, Pilowsky was less commanding than Maddison, but was able to influence his colleagues through the quality of his ideas and rigor of his publications.

In 1971, Pilowsky moved to South Australia to accept the Chair of Psychiatry at the University of Adelaide. Much of Pilowsky's clinical research centred on the perceptions and attitudes of patients attending multidisciplinary pain clinics.¹⁵ Pilowsky developed a theoretical model to assist clinicians to conceptualise experiences of pain and illness, and a

model by which they would be able to communicate their findings to other clinicians. By modifying David Mechanic's concept of 'illness behaviour' Pilowsky developed a new concept which he labelled 'abnormal illness behaviour' (hereafter AIB).¹⁶⁻¹⁷ He defined this concept as:

The persistence of an inappropriate or maladaptive mode of perceiving, evaluating or acting in relation to one's own state of health, despite the fact that a doctor (or other appropriate social agent) has offered an accurate and reasonably lucid explanation of the nature of the illness and the appropriate course of management to be followed, based on a thorough examination of all parameters of functioning, and taking into account the individual's age, educational and sociocultural background.¹⁸

According to Pilowsky, AIB might present itself as either 'illness affirming' or 'illness denying'. That is, some patients perceived their medical conditions to be worse, or more dangerous, than their physicians considered them to be, while other patients believed that they were in less danger from their symptoms than their doctors judged them to be. An example of illness affirmation would be a person who exhibited psychogenic pain or non-epileptic convulsions. An example of illness denial would be a patient who disputed the relevance of a cerebral stroke or a myocardial infarction and refused to alter their daily behaviour in keeping with medical recommendations. Pilowsky's model is especially useful when the extent of physical pathology, or its importance in the causation of their symptoms, is unclear—which is very often the case in general medicine. The AIB model quickly gained the acceptance of a wide range of health professionals and was soon adopted internationally. Consultation-liaison psychiatrists welcomed Pilowsky's model because it provided a useful way to formulate the problems of many of the patients they encountered in medical settings. It allowed psychiatrists, and other clinicians, to accurately communicate clinical information.

The model could also sometimes be used to convey information to the patient. Its usefulness in clinical settings paved the way for the construction of a reliable measuring instrument to be employed in clinical research. Pilowsky labelled this instrument the Illness Behaviour Questionnaire.¹⁹

When Gordon Parker published a list of Australian psychiatrists who had made distinct contributions to international psychiatry, Pilowsky was among his five nominees.²⁰ In Australia, and in New Zealand, Pilowsky had a significant influence on the education and on the clinical thinking of a generation of psychiatrists, general physicians and medical students. His contribution to consultation-liaison psychiatry is also discussed in this dissertation in *Chapter Twelve: The birth and growth of consultation-liaison psychiatry in NSW*. In 1987, Pilowsky was diagnosed as suffering from a brain tumour, but he was able to fulfill his duties at the University of Adelaide until 1997. In 1991 he was awarded Membership of the Order of Australia. Issy Pilowsky succumbed to his brain tumour in 2012.

11.5 The relevance of the School of Psychiatry at the University of New South Wales to the development of general hospital psychiatry

As noted in an earlier chapter, the second academic School of Psychiatry in NSW was founded in 1962 at the University of New South Wales by Dr Leslie Kiloh. Before his migration to Sydney, Kiloh had established an excellent international reputation for his research on the diagnosis, categorisation and treatment of affective disorders. His approach to research was biological and, throughout his career Kiloh remained critical concerning many of the claims of social theorists and psychoanalysts. Kiloh never became deeply involved in the Royal Australian and New Zealand College of Psychiatrists and was not a political force outside academia. Although committed to a biological or neurological approach to

psychiatric treatment and research, Kiloh welcomed academics to his new school who had differing goals and interests. Among the first recruits were Gavin Andrews, Neil McConaghy and John Cawte. McConaghy's career centred on behavioural therapeutic approaches to treatment. Cawte was particularly interested in indigenous psychiatry and that is where he left his mark as a researcher. Gavin Andrews had a wide range of research interests. During the 1980s and the 1990s, Andrews published significant papers on many topics, including ones on cognitive-behaviour therapy, epidemiology and concerning the distribution and effectiveness of health services in Australia. Notwithstanding the professional achievements of the first academic psychiatrists at the University of New South Wales School of Psychiatry it is arguable that they had less impact on the trajectory of psychiatric services in NSW than David Maddison or Issy Pilowsky. [The author wishes to acknowledge that his judgment might be biased because of his former affiliations with Maddison and Pilowsky and because of his present affiliation with the Discipline of Psychiatry at the University of Sydney.]

11.6 Conclusions

Working together at the University of Sydney and at linked clinical institutions, David Maddison and Issy Pilowsky commenced careers that they hoped would advance psychiatric education, psychiatric clinical practice and psychiatric research in NSW and in other jurisdictions. During the 1970s Maddison focussed much of his energy on the education of the medical profession, including its psychiatrists. He intended to bring the attitudes, insights, knowledge and skills of psychiatrists into medical education. He wished that faculties of medicine would become less detached from patient care and more alert to humanistic values. During the same decade, but now in Adelaide, Pilowsky developed a conceptual model which would allow health professionals better diagnostic and therapeutic access to disorders that lay in a clinical domain between medicine and psychiatry. Maddison and Pilowsky each had an

impact on the trajectory of psychiatric education, on medical education, on psychiatric services and on the role and the importance of psychiatry within general medicine in New South Wales and in other parts of Australasia. Maddison's influence on the evolution of psychiatric services in NSW was greater than Pilowsky's, but Pilowsky's influence on the evolution of consultation-liaison psychiatric services in Australia was more direct than Maddison's—an eventuality that will be explained in *Chapter Twelve*.

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Chapter Twelve

The birth and growth of consultation-liaison psychiatric services in New South Wales

12.1 Introduction

Chapter Twelve provides a narrative account of the inception and growth of consultation psychiatry and liaison psychiatry in the general hospitals of New South Wales. Liaison psychiatry was born in the USA in the 1920s but would not reach Australia until the late 1960s. In the latter decade, liaison psychiatric attachments became possible in NSW because of the coincidence of the specific needs of some medical and surgical teams and the availability of psychiatric resources that could meet those needs. A major influx of mental health professionals into the general hospitals of NSW in the 1960s and 1970s meant that it became possible to provide certain psychiatric services to the medical, surgical and obstetric inpatients and outpatients of those hospitals. The heads of medical and surgical departments responded to the availability of mental health professionals by asking them to collaborate in the management of medical and surgical patients who had unmet psychosocial needs or who were about to undergo potentially stressful new treatments. The chapter concludes with a comparison of developments in consultation-liaison psychiatry in NSW with those developments in the UK and the USA.

12.2 The earliest occasions of psychiatric consultation in the wards of general hospitals in New South Wales

In 1882, when RPAH admitted its first inpatients, Norton Manning was automatically entitled, as an examiner and as a lecturer in the Faculty of Medicine at the University of

Sydney, to perform psychiatric consultations. Whether he took advantage of this professional privilege is unclear. An overview of Manning's approach to professional responsibilities suggests that he would have agreed to perform those consultations, but the earliest case notes of patients at RPAH have not survived to provide historical evidence that this ever happened. In 1923, when Sir John Macpherson took up his appointments as Professor of Psychiatry, and as head of the Department of Psychiatry at RPAH, he would certainly have performed psychiatric consultations. Unfortunately, and as in the case of Manning, no records of such consultations have survived.

In 1929, the Inspector-General of Mental Hospitals, Charlie Hogg, recorded that OPD clinics were functioning at nine hospitals in New South Wales: RPAH, Sydney Hospital, St Vincent's, Lewisham, Royal North Shore, Parramatta, Newcastle, Goulburn and Orange (General Hospital).¹ The psychiatrists who provided outpatient services would likely have been asked to also perform consultations on inpatients. However, Dr AT Edwards recorded that, when he became an honorary consultant psychiatrist at Sydney Hospital in 1946, '... it was rare to be called to consultation by any other specialist.' Edwards left no additional information concerning his performance of psychiatric consultations.² In 1955, psychiatric outpatient clinics were functioning at eleven adult general hospitals in NSW and at the Children's Hospital.³ The Stoller & Arscott Report noted that those OPD clinics were not properly designed for psychiatric consultations, which suggests that the clinics were not designed in a way which would protect the privacy of interviews.³ The functioning of the OPD clinics at RPAH in the 1920s and the 1930s, and at St Vincent's Hospital in the years 1966 and 1967 was discussed in *Chapter Seven* and in *Chapter Ten*.

12.3 What is liaison psychiatry?

Many authors have commented that the terminology surrounding liaison psychiatry is somewhat confusing. In this dissertation the terms ‘consultation-liaison psychiatry’ and ‘liaison psychiatry’ are used interchangeably and connote the same subspecialty function. An authority on this subject, ZJ Lipowski, defined the subspecialty as follows:

Liaison psychiatry is that subdivision of clinical psychiatry which involves consultation to and collaboration with non-psychiatric physicians in all types of medical settings, but especially in general hospitals. It is primarily concerned with problems of diagnosis, management, study and prevention of psychiatric morbidity in the physically ill and in those who manifest their distress in the form of somatic complaint.⁴

In the context of psychiatric services, the title ‘liaison’ indicates a mode of psychiatric practice in which the psychiatrist collaborates with other attending doctors and nurses. Rather than confining attention to formal consultation processes the liaison psychiatrist attempts to sensitise physicians, nurses, and other health workers to the psychosocial dimensions of illness, to teach them to recognise and manage psychopathology and to improve communication between patients and staff.⁴ Since the inception of liaison psychiatry in the USA in the 1920s, its most ambitious goal has been to overcome a problem that has bedevilled general medicine throughout the twentieth century: the barrier that modern medicine and its complexity has created between doctors and patients. The historian Charles Rosenberg refers to this problem in asking:

How do you organise health care so it deals, on the one side, with the technical necessities and, on the other, with what you might call the human necessities?⁵

In 1975, David Maddison offered a response to such a question by asserting that psychiatry was crucial to 'the humanisation of medicine'.⁶ Maddison's medical and psychiatric philosophies were discussed in the preceding chapter.

12.4 The birth and development of liaison psychiatry in the USA

Liaison psychiatry was born in the USA in the 1920s. Thereafter it grew slowly until the 1960s when its practitioners in that country began to multiply.⁷ One of the earliest, if not first psychiatrists to describe a liaison function for psychiatry was George Pratt who did so in a paper published in 1926.⁸ Pratt was not alone in turning his attention to this emerging approach to clinical interventions at the interface of medicine and psychiatry. In the 1920s and 1930s, several American psychiatrists proposed that psychiatric services should find a home in general hospitals and in general medicine.⁹⁻¹² During the 1930s Alan Gregg nurtured the entrance and development of psychiatric services in many of the leading general hospitals of North America.¹³ The Federal Government of the USA followed the example of the Rockefeller Foundation by giving its support to psychiatric services in the general hospitals. Between 1945 and 1980, consultation-liaison psychiatry went through a developmental phase, during which many clinical, research and educational programs concerning liaison psychiatry were devised and implemented.⁷ In the middle of that developmental phase, John Romano, George Engel and their colleagues established a mecca for liaison psychiatry in Rochester, NY. However, after 1980 the sub-specialty of liaison psychiatry, along with other components of general hospital psychiatry, entered a phase of consolidation and, in some places it faltered. Training grants provided by the National Institute for Mental Health (hereafter, NIMH) had encouraged the growth of consultation-liaison during the 1970s, but then began to shrink and were discontinued in 1985.¹⁴ A national survey of general hospitals of the USA in 1987 demonstrated that less than one percent of patients in those hospitals

were referred for psychiatric consultation. This was a smaller percentage than had been reported in the preceding decade, and only about one twentieth of all the patients in general hospitals who experienced significant psychiatric difficulties received psychiatric consultation.¹⁵

After 1980, the introduction of ‘managed care’ had a restraining and often destructive effect on general hospital psychiatry and on consultation-liaison psychiatry in the USA.^{16,17}

Commenting on the fate of liaison psychiatry between the 1920s and the 1980s, psychiatrist-historian John Schwab makes the pithy statement: ‘The overriding problem is monetary.’¹⁴

Aspects of the growth of liaison psychiatry after 1980 were mentioned earlier in this dissertation in *Chapter One: Literature review*. It was also noted in *Chapter One* that consultation-liaison services did not appear in the UK until the late 1950s, and only did so in a few academic departments of psychiatry in Britain’s principal cities.

12.5 Liaison psychiatry reaches Australia

Throughout this dissertation, it has been emphasized that, for more than one hundred and fifty years, the leaders of psychiatric services in NSW drew inspiration from the UK but that, after the Second World War, they became increasingly interested in developments in psychiatric services in the USA. As mentioned in earlier chapters, several leaders of the Australian psychiatric profession travelled to the USA during the 1960s and the early 1970s on sabbatical and other leave to study developments in psychiatric thinking and to examine innovations in psychiatric services. The first psychiatrist to establish a comprehensive liaison psychiatric service in Australia was neither born nor trained in Australia. Dr Wallace Ironside, a Scottish psychiatrist, accepted the foundation Chair of Psychiatry at Otago in 1953. Between 1959 and 1961, while on sabbatical leave from Otago, Ironside studied the

biopsychosocial model of illness and liaison psychiatry with Engel in Rochester. In 1969, Ironside migrated from Otago to Melbourne to accept the foundation Chair of Psychiatry at Monash University and to launch an ambitious consultation-liaison service at Prince Henry's Hospital. In 1974, Ironside's Department supervised eleven trainee psychiatrists, five of whom were working in liaison attachments.¹⁸ Prince Henry's Hospital was one of several institutions which amalgamated, in 1992, to form the Monash Medical Centre. In the Australian psychiatric community, many consider that the liaison services at Prince Henry's Hospital, and at its successor, the Monash Medical Centre, to be the preeminent liaison psychiatric service in Victoria, if not in the whole of Australia. Smith, Clarke and Hermann described the development of those services in 1993. Writing for an American psychiatric journal, they noted that, in Australia 'C-L psychiatry is extremely well developed in some centres but still rudimentary in others.'¹⁹ As an example of this uneven development, they noted that the Monash Medical Centre had 3.0 full time employed (hereafter, FTE) psychiatrists, 6 trainee psychiatrists, 3.5 FTE psychologists and 1 FTE nurse specialist, and handled 1,500 consultations per year, but that the Dandenong Hospital, on the outskirts of Melbourne, had only 0.5 FTE psychiatrists and one trainee psychiatrist, and handled 400 consultation requests per annum. Smith, Clarke, and Hermann concluded 'Despite conditions favourable to its growth, C-L psychiatry has been slow to develop in Australia.'²⁰ The paper does not give many details concerning psychiatric liaison services in NSW nor in the other Australian states or territories.

In the 1960s and 1970s, the mental health professionals who were appointed in the new general hospitals psychiatric services were, by and large, inspired by two ideologies. Consequently, they tended to fall into two camps: a 'social/reformist group' and a 'medical group'.²¹ The 'medical group' felt that linking psychiatry and general medicine was central to

the purpose and to the growth of general hospital psychiatry.²¹ Members of the medical group oftentimes also identified as members of a general hospital community and emphasized their status in the medical and nursing professions. It was of particular importance for these mental health professionals that psychiatry be understood as a provider of care and treatment to patients who had physical illnesses or symptoms. Liaison psychiatrists belonged to this group. They did not negate or devalue the importance of offering psychiatric services to geographic communities, but they wished to focus their professional energies elsewhere. The sentiments of the medical group concerning the responsibilities of psychiatry towards the general hospitals to which they were appointed mostly aligned with those expressed in 1967 by John Woodforde and in 1977 by Peter Burvill. The goals of those mental health professionals were discussed at some length in *Chapter Ten*.^{22,23}

12.6 Requests by physicians and surgeons for the attachment of liaison psychiatrists to their teams and to their departments

Prior to the 1960s, most physicians and surgeons enjoyed semi-independent practices within the general hospitals. They saw little need to form discrete departments and sub-departments. However, with the advent of new technologies, such as radiology, radiotherapy, renal dialysis and organ transplantation, physicians and surgeons realised that, if they wished to utilise those complex technologies and techniques, they must create cohesive specialty departments. An example of this phenomenon is seen in the field of renal medicine. Renal dialysis machines, which could sustain the lives of patients when their kidneys had failed, were introduced into general hospitals in the 1960s. Around the same time it became possible to replace the kidneys of some patients who had end-stage renal disease by performing renal transplantation from living donors or deceased donors. The management of patients by renal dialysis and by renal transplantation required the closest possible collaboration of physicians,

nurses and technologists, and led to the formation of departments of renal medicine. Patients who commenced renal dialysis had to be attached to dialysis machines for many hours on several days of each week. As a result, dialysis placed patients under great physiological, psychological and social stress. Responding to these complex clinical situations, heads of departments of renal medicine asked psychiatrists to join their teams to give direct support to dialysis patients and to persons contemplating renal transplantation and to advise the members of their teams on the optimal psychiatric management of those patients. The success of liaison attachments to departments of renal medicine was noted by the heads of departments of oncology, intensive care, rehabilitation medicine and geriatric medicine who were quick to seek similar arrangements.

12.7 The first liaison psychiatry attachments in three major general hospitals in Sydney: St Vincent's Hospital, Royal Prince Alfred Hospital and Sydney Hospital

Clinical services commenced at the Caritas Centre at St Vincent's Hospital in 1962, but several years elapsed before construction of the inpatient service was completed. In an article written in 1967, which was discussed at length in *Chapter Ten*, Dr John Woodforde described two varieties of 'liaison' responsibility that he accepted as the Director of the Caritas Centre-- one intramural and one outside the hospital.²⁴ According to Woodforde, all of his clinical staff-- including nurses, occupational therapists, social work and psychologists--provided mental health consultation throughout the hospital, and his psychiatrists provided liaison advice in the intensive therapy ward (Woodforde, 1967)²⁵ and in the pain clinic (McEwan et alii. 1965).²⁶ He also noted the participation of a liaison psychiatrist in neurological research.²⁷

In 1969, Dr Issy Pilowsky accepted a liaison psychiatric attachment in the Department of Renal Medicine at the Royal Prince Alfred Hospital. Two years later, Pilowsky moved to Adelaide to succeed William Cramond as the Chair of Psychiatry at the Royal Adelaide Hospital and as the liaison psychiatrist in its Department of Renal Medicine. At RPAH, the Visiting Medical Officer, Dr Ron Vickery took over the liaison attachment with Renal Medicine and maintained and developed it further during the next two decades. In 1978, Dr Greg Steele was appointed as a full-time staff specialist at RPAH with responsibility for the administration of psychiatric outpatient and consultation-liaison services. Steele managed a high proportion of the consultations performed in the emergency department and in the medical, surgical and obstetric wards. In 1980, he published an account of the consultation-liaison service in the in-house journal 'RPA'.²⁸ Also in that year, the consultant staff of the consultation-liaison unit (hereafter, C-L or C-LP unit) consisted of one full-time staff specialist psychiatrist (Steele himself) and five Visiting Medical Officers (hereafter, VMOs), one of whom was the present author. The C-L unit had attachments to the Emergency Department, the Pain Clinic, Neurology and Neurosurgery, Endocrinology, and to the Department of General Medicine. Steele held weekly meetings with the psychiatric nursing liaison team to discuss clinical problems that had arisen in the various wards of the hospital. This team consisted of two senior psychiatric nurses, employed by, and answerable to, the nursing division of RPAH. These nurses regularly visited all wards and provided counsel on psychosocial and psychiatric issues whenever those issues arose. Such issues included the identification and management of delirium, anxiety and depression, and the management of non-compliant and oppositional behaviour.²⁹

In 1974 or 1975, Dr Maurice Sainsbury accepted an honorary liaison attachment to the Melanoma Clinic at Sydney Hospital. In that year, Sainsbury, who was the Director of the

Institute of Psychiatry at Rozelle, joined with Professors Jim McLeod (Neurology, Sydney Hospital) and Douglas Joseph (Anaesthetics, RPAH) on an assignment in China on behalf of the National Health and Medical Research Council (NH&MRC) aimed at investigating and reporting on the medical applications of acupuncture.³⁰ In 1975, Sainsbury co-authored a paper with Professor Gerry Milton that describes a series of meetings with nurses who attended patients in the cancer ward at Sydney Hospital.³¹ There were four or five honorary psychiatrists also working at Sydney Hospital in the mid-1970s, but their duties seldom extended beyond the OPD Clinics. In those years Sydney Hospital had between 200 and 300 beds; in the 1980s, after the main specialty services at Sydney Hospital had been relocated to other hospitals, it ceased to be a major teaching hospital.

In the mid-1970s the NSW Department of Health created staff specialist psychiatrist appointments in two major Sydney hospitals that had no psychiatric beds: the Prince of Wales Hospital – where Dr Noel Wilton was appointed as liaison psychiatrist in 1973 – and Sydney Hospital, where the present author was appointed in 1975. [Those duties and some of the perceptions of the present author are described in *Appendix Three: Professional Memoir* that is attached to this dissertation.] Also in 1975, Dr Richard Perkins was appointed to a newly created staff specialist position in liaison psychiatry at the Prince Henry Hospital. Prince Henry Hospital had an academic inpatient unit which had been functioning for nine years. Perkins was employed to split his time between consultation-liaison duties at Prince Henry Hospital and in community services in an adjacent suburb. It is important to note that these three staff specialist liaison psychiatric positions were created while Bill Barclay was the Commissioner for Personal Health Services and was effectively in charge of all the mental health services of NSW. Barclay did not publish his views about the new subspecialty of consultation-liaison psychiatry, but it was the author's experience, as both a witness to and

participant in these events, that Barclay was very supportive of the work of the new liaison psychiatrists and of the goals of their new subspecialty. In Barclay's writings and in his oral presentations, Barclay showed commitment to the development of community-focussed psychiatric services³², but, as the head of the psychiatric services for NSW, he gave strong practical support to the birth and the growth of C-L services in the State's general hospitals. During the 1970s, C-L services were established in all the principal general hospitals of NSW.

12.8 The status and the growth of the subspecialty of consultation-liaison psychiatry in NSW after 1980

The responsibilities of liaison psychiatrists are onerous. In order to provide one-to-one attention to the patients of the medical departments to which they are attached, liaison psychiatrists must make themselves available for many hours per week. They must also set aside time to interact and to communicate with doctors, nurses and social workers who attend those patients. Therefore, liaison psychiatrists who attach to certain medical and surgical departments must be prepared to work out-of-hours. The demanding nature of the work in a liaison attachment was emphasized by Pilowsky during a Geigy Symposium in Adelaide, in 1977.³³ According to Pilowsky, liaison psychiatrists had to be equipped, by temperament and by training, to deal with complex interpersonal and psychosocial problems. They also had to be well versed in the use of psychopharmacological and other medical and surgical treatments.

Earlier in this chapter, it was explained that consultation-liaison psychiatry only became possible in NSW after 1960, when many mental health professionals had joined the staff of the general hospitals and when the heads of medical and surgical departments asked some of

them to accept attachment to their clinical teams. To explain the rapid expansion of C-L psychiatry in NSW in and after the 1970s, three additional factors should be considered. These will be examined in the next few pages.

In 1978, the Royal Australian and New Zealand College of Psychiatrists (hereafter, RANZCP) published ambitious *Training Guidelines* directing that those medical practitioners who wished to qualify for Fellowship of the College must complete six months of supervised experience in an approved C-L service in a general hospital at some stage within their five years of post-graduate training in psychiatry. In 2003, when those guidelines were formally reviewed, representatives of the National Association of Psychiatrists-in-Training insisted that six months of experience in liaison psychiatry provided the only good supervision in medical-psychiatric consultation and that that component of their training could not be reduced. These trainees, the majority of whom would eventually enter private practice, believed that this component was essential to their future success as practicing psychiatrists.³⁴ The requirement of six months of supervised experience in C-LP before accreditation as a consultant psychiatrist was, in 1994, a training requirement unique to Australia and New Zealand. The American Board of Neurology and Psychiatry only required two months of experience in liaison psychiatry and the British Royal College of Psychiatrist had not stipulated any period of supervised experience in C-LP.³⁴

The second factor nurturing the growth of C-LP in Australia was the cultural climate of Australian psychiatry, and the attitude of most Australian psychiatrists towards psychodynamic theory and practice. When Smith, Clarke, and Herman sought to explain the welcome offered to liaison psychiatry by Australian psychiatrists, they wrote, 'Psychoanalysis had become well established in the larger Australian cities after the 1940s,

and its influence on Australian psychiatry provided a fertile field for the introduction of the ideas of liaison psychiatry.³⁵ This contrasted with the attitude of many British psychiatrists towards psychoanalytic and psychodynamic ideas, which varied considerably but was sometimes very negative. In an after-dinner speech in 1991, Graeme Smith said that certain academic departments of psychiatry in the United Kingdom had a history of ambivalent or hostile attitudes towards psychoanalytic tenets. Smith said that some of those psychiatric attitudes had been introduced to Australia when British psychiatrists had migrated here in the post-war period.

Those academic influences were largely British, and for Psychiatry they were largely Newcastle and Maudsley influences. They were certainly not psychoanalytic. There was thus something of a clash between academic units and the general hospital psychiatry culture.³⁶

The third factor that favoured the growth of GHP, especially in New South Wales, was the attitude of governments – federal and state. Both levels of government promoted policies concerning mental health that gave attention to a broad spectrum of psychiatric disorders, and both levels favoured a wide range of biological, psychotherapeutic and social strategies. The Commonwealth Government always supported the growth of the private practice of psychiatry. In 1975, the Whitlam Government made access to psychiatric care available for all Australians by creating a system of universal health insurance called Medibank. That system was attenuated by the Fraser Government but restored by the Hawke Government in 1984 under the new title of Medicare. Medicare provides considerable security and stability for liaison psychiatric services throughout Australia by guaranteeing that the Commonwealth Government will provide sufficient recurrent funding for the maintenance of the public hospitals and for the medical services of all the Australian states and territories.

After 1986, when the NSW Government created geographically delineated Area Health Services, it channelled its recurrent funding through statutory boards which administered those Area Health Services. In 2011, the Area Health Services of NSW were realigned and relabelled Local Health Districts. Local Health Districts exercise some discretion in the way that they distribute funds that they receive from the NSW State Government. It is an accepted, but sometimes frustrating fact-of-life that all health subgroups, including C-LP services, must engage in an annual competition for a share of the resources which are distributed by the boards of the Local Health Districts.

In 1992, Australian health ministers came together to formulate the First National Mental Health Policy (1992). It is commonly thought that the mental health services of Australia have benefited from the maintenance of national oversight on mental health issues. However, the exact wording of one of the policies which was published in the First Plan soon became a source of contention between various subgroups within the psychiatric services. This policy stated that priority should be accorded to persons who had ‘severe mental health problems or mental disorders’.³⁷ Those mental health professionals who worked in community-focussed services interpreted this to mean that public health resources should be directed towards the management of the severest categories of mental disorder, which are generally accepted to be schizophrenia, bipolar disorders and severe personality disorders. The community-focussed services argued that they were more entitled to resources than the consultation-liaison subgroup because their subgroup was responsible for the ‘integrated’ management of those disorders. Such a line of argument proved beneficial to community-focussed services for several years after the introduction of the First National Mental Health Policy.

During the early 1990s, in certain hospitals in Victoria, liaison psychiatry suffered from cutbacks.³⁸ Similarly, but with slightly less success, there were also attempts to cut back expenditure on C-LP services in NSW. In 1998, the framers of the Second Australian National Mental Health Plan argued that the intended meaning of ‘serious mental illness’ in the First Plan had been misinterpreted. Drawing on evidence provided by the World Bank and the World Health Organisation, the Second Plan noted that non-psychotic disorders, including depression, fatigue and anxiety, had profound effects on health outcomes and were responsible for a massive burden-of-disease.³⁹ The Second (1998-2003) and Third National Mental Health Plans (2003-2008) accorded more priority than the First Plan (1993-1998) to the degree of disability caused by mental disorders. This gave the consultation-liaison psychiatrists ammunition in the annual competition with other groups for funding and other resources. They could, for example, cite research that demonstrated a strong association between depression and heart disease and research that showed that, when heart disease and depression were comorbid, the degree of disability correlated better with measures of depression than with measures of cardiac function or measures related to diabetes. Moreover, they were able to cite evidence that the depressed mood associated with heart disease was very treatable.⁴⁰

A Section of Consultation-Liaison Psychiatry of the RANZCP was established in 1995. It commenced with 225 members, which was approximately a sixth of the Fellowship of the RANZCP at that time. Between a quarter and a third of the members of the Section of C-LP were from NSW. The Section was destined to become a Faculty in 2015. By 1994, physicians, surgeons and medical administrators in the major general hospitals of NSW regarded consultation-liaison psychiatry to be an essential component of the clinical services

which they were obliged to provide to their inpatients and outpatients, thereby securing its place in the health services of the Australian states and territories.

12.9 A comparison of the growth and development of C-LP in the United Kingdom, the United States of America and in New South Wales

Since 1948, the mental health services of the UK have been part of the National Health Service (NHS) and, as such, almost totally reliant on the NHS for funding. For the first decades of the existence of the NHS, the introduction of consultation-liaison services into the UK had no place among its health priorities. In the 1960s, certain academic departments of psychiatry in London, Oxford, Edinburgh and Manchester adopted research interests in liaison psychiatry and created small clinical C-L services. However, these departments were limited to their principal teaching hospitals. Consequently, liaison psychiatric services in Britain remained unevenly distributed. Some details of these developments are provided in *Chapter One*. In 1988, a survey of psychiatrists belonging to a liaison interest group within the Royal College of Psychiatrists showed that thirteen new non-academic posts had recently been created in district hospitals. The survey's author, Professor Else Guthrie commented that there had been recent growth in liaison psychiatry, but that, for several reasons, liaison psychiatry in Britain faced 'an uncertain future'. Among those reasons she noted that 'resources for mental illness were focused more and more on "the severely mentally ill."' Guthrie questioned whether the recent expansion would be sustained or whether it represented 'a bubble that is about to burst?'⁴¹ In 1991, Richard Mayou commented that the development of liaison services in Britain had been hindered both by 'a general lack of resources and by an overwhelming planning bias towards community care, such that only a minority of local health districts have definite plans to improve C-L services.'⁴² The Royal

College of Psychiatrists established a Section of Liaison Psychiatry in 1997—two years after the RANZCP had established its Section of Consultation-Liaison Psychiatry.

Liaison psychiatry grew slowly in the US between 1920 and 1960, after which it experienced rapid growth for two decades. In the 1980s, however, the Federal Government began to limit its financial support for health services. This led to a phase of hesitation and ‘consolidation’ in C-LP services.¹⁴ Liaison services became more vulnerable to changing financial circumstances at the administrative level of hospitals, cities and states. At the same time, liaison services were forced to contend with ‘managed care’: health insurance organisations began to limit the freedom of the medical profession, and of American hospitals, to determine their clinical practices.^{16,17} Moreover, liaison psychiatrists now had to survive in a marketplace where they were forced to compete for resources with departments of medicine and surgery as well as with other sectors of psychiatry.^{16,17} In 1994, liaison psychiatry had not, in the USA, been formally identified as a subspecialty area within psychiatry. Its advocates feared that it had not sufficiently embedded itself in the education of primary care physicians. If liaison psychiatry were to advance its prospects in the USA it would need to escalate its research efforts and prove its effectiveness to the organisations which funded health services.⁴³

12.10 Conclusions

In the 1920s, when psychiatric outpatient clinics were created in the major general hospitals of NSW, the psychiatrists who attended those clinics would probably have answered requests to provide psychiatric consultations on inpatients in those hospitals. Liaison psychiatric services were conceived in the USA in the 1920s and were largely confined to that country until the 1960s when small liaison services were created in a few major hospitals in the UK,

and in Australasia. For reasons that were discussed throughout this chapter, mental health professionals in New South Wales were able to launch consultation-liaison psychiatric projects and to gain significant traction in general hospitals. By 1994, C-LP was securely established in New South Wales. In real terms, and in terms of ambition and maturity, C-LP services in NSW seemed to be on a par with, and may sometimes have been clinically more advanced than, C-LP services in other anglophone countries.

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Chapter Thirteen

Defence of the thesis

13.1 Introduction

Chapter Thirteen summarises and consolidates the argumentation provided in earlier chapters in defence of the contention that was stated in the Introduction to this dissertation.

Throughout this dissertation the evolution of general hospital psychiatric services in New South Wales has been compared with the evolution of those services in the United Kingdom and in the United States. In this chapter the argumentation is divided into three periods.

During the first period, between 1788 and 1898, the general hospitals avoided any role in the accommodation or the management of insane persons. During the second period, between 1898 and 1961, the general hospitals considered the option of accepting a limited role in the assessment and management of certain mental disorders and some of them accepted that role.

During the third period, between 1961 and 1994, there was a major relocation of acute psychiatric services from the mental hospitals into the general hospitals, followed by a subdivision of those services into community mental health services and psychiatric consultation-liaison services.

13.2 Argumentation concerning the first period, 1788 to 1898: General hospitals avoid any role in the management of insanity

Between 1788 and 1898, the general hospitals in New South Wales did not accept any role in the management of insanity. The relevant passage from the stated contention in the Introduction was as follows:

In this dissertation, I will argue that the historical development of general hospital psychiatry in New South Wales initially followed a pattern that had been

set in Britain but was influenced by local factors, which included the large distances between centres of population and the necessity for local modifications of British systems of governance and administration.

Between 1788 and 1898, the mental health services of New South Wales followed a developmental trajectory that resembled ones that had been established in Britain, but with modifications required to deal with the great distances between centres of population and the unique characteristics of the governance and administration of the Colony of NSW. Sydney was separated from London by more than twenty-one thousand nautical kilometres and from its furthest local territorial outpost in Norfolk Island by more than sixteen hundred kilometres. The first colonists realised that they must discover how to survive in an environment which was often inhospitable and to learn how to utilise and to cultivate local resources. Those newcomers to the antipodes belonged to a penal colony which was autocratically ruled by a representative of the British Crown—the Governor of New South Wales. This non-indigenous society clung, as best it could, to British legal and administrative procedures, to British social customs and to British medical practices, including those concerning the management of insanity.

In 1811, the Colony of New South Wales took the first step towards building a system of lunatic asylums that would come to resemble its counterpart in the United Kingdom. The first of these asylums was created by the conversion of a military barracks at Castle Hill, about thirty-five kilometres to the north-west of Sydney Cove. In 1838 a lunatic asylum was purpose-built at Tarban Creek, about eleven kilometres to the west of Sydney Cove. One of the earliest laws passed by the first partly elected Legislative Council of New South Wales was the Dangerous Lunatics Act (1843). That law guaranteed that admissions to lunatic

asylums were only legally possible if two medical practitioners certified that a person was insane and dangerous or suicidal or intent on committing a criminal act. There was a separate provision in the 1843 Act for the management of persons who were not free settlers or freed persons but who were transported convicts. Otherwise, the provisions of the Dangerous Lunatics Act (1843) resembled those in mental health legislation in the United Kingdom.

In 1867, Dr F Norton Manning, a young British naval surgeon, accepted the invitation of the Colonial Secretary, Henry Parkes, to succeed Dr Francis Campbell as the resident medical superintendent of the Tarban Creek Lunatic Asylum, which Manning quickly renamed the Hospital for the Insane at Gladesville. In 1878 Manning became the first Inspector-General of the Insane for NSW and effectively the executive director of the mental health system of NSW.¹ Throughout the three decades of his career as Australia's leading alienist, Manning remained a British alienist in every respect other than his domicile in the Colony of New South Wales. However, Manning was always well-informed about psychiatric services in other parts of the world and was very well informed about psychiatric services in the United States. During his 1867-68 international study tour of mental asylums, Manning visited several major mental hospitals in the USA and spoke with leading American alienists of the day, including Dr Thomas Kirkbride. Manning knew that the management of insanity in the United States was not essentially very different from its management in Britain. Throughout his tenure as Inspector-General of the Insane (1878-1897), Manning was comfortable with the fact that the laws concerning insanity in NSW—many of which he had personally drafted and which came into effect in 1878—resembled those in Britain.

A description of the psychiatric services of NSW in the last decades of the nineteenth century was provided in *Chapter Five: The management of lunacy in New South Wales in the late*

nineteenth century. By 1898, it seems that the standards of accommodation and management of insane persons within the mental hospitals of NSW compared well with those in the United Kingdom but Manning faced a problem which was far less challenging in the United Kingdom: the great distance between centres of population in NSW made it difficult to provide services for colonists in country areas who became insane. Country towns were often hundreds of kilometres from the mental hospitals in Sydney and Parramatta. Manning wished that certified patients would be managed in country hospitals until they could be moved to Sydney, but the general hospitals absolutely refused to admit certified patients. Consequently, mentally ill persons had to be detained in jails until suitable transportation to Sydney could be arranged. The detention of insane persons in jails exposed them to risk and discomfort and to the stigma of criminality.

In the last decades of the nineteenth century, there were innovations in parts of the mental health services of the UK that would not be duplicated in NSW until the 1920s. These innovations were noted in *Chapter One: Literature review: The evolution of general hospital psychiatry in the United Kingdom and in the United States of America*. Accurate references concerning the data in that chapter are provided as endnotes to that chapter. In Glasgow, in 1883, a ward was created in a general hospital for the management of patients who had non-certifiable psychiatric disorders. In Manchester some voluntary inpatient mental health facilities were created well apart from the major mental hospitals. By 1898 several psychiatric outpatient clinics had been established in general hospitals in Scotland and in Manchester and London. In Scotland there were legal and administrative arrangements for the boarding out of certain patients from mental hospitals—arrangements that were not thought appropriate for introduction into New South Wales.

When one considers whether there were any jurisdictions, other than the UK and the USA, where there was a source of psychiatric philosophy and activity that was strong enough to influence the trajectory of the development of psychiatric services in NSW, one sees that the only major contender was Germany. During his study-tour of mental asylums in 1867-68 Norton Manning visited twenty-five asylums in England, fourteen in the USA, nine in Scotland, nine in France, five in Belgium, four in Germany and one in New Zealand. He also inspected nine lunacy wards in workhouses in Britain. In his published Report on Lunatic Asylums, Manning did not single out German mental asylums for special comment or say much about the German system of asylums, but he quoted a page from an influential book by Professor Wilhelm Griesinger in which Griesinger commented on the ideal siting of mental asylums.² Manning also recorded a light statement he attributed to Professor Ludwig Meyer about the importance of attractive meals in the asylums of Germany. In Manning's Annual Reports between 1868 and 1897 there were few, if any, references to German psychiatric services. I concluded that Manning did not rely on German sources when he built the foundations of the psychiatric services of New South Wales. This is not surprising, because the practical outcomes in psychiatric services that were heralded by Wilhelm Griesinger, only started to appear in Germany after 1868, the year in which Manning that country. The most dramatic outcomes of the German experiment in psychiatric services would become evident, especially in Heidelberg and in Munich, two decades after Manning's visit, when Emil Kraepelin was in his prime.³ However, I concede that there is room for further research concerning the possible influence of developments in psychiatric services in Imperial Germany and the development of psychiatric services in Australian jurisdictions.

13.3 Argumentation concerning the second period: 1898 to 1961

The relevant passage within the contention that was recorded in the Introduction to this dissertation reads as follows:

During the first phase of the era of general hospital psychiatry, between 1898 and 1961, psychiatry established a small but important foothold in the general hospitals of New South Wales. However, after 1948 the trajectory of psychiatric services in New South Wales started to depart from the one that was being adopted in Britain.

The development of psychiatric services in New South Wales between 1898 and 1961 is described in *Chapter Seven: Under the leadership of Eric Sinclair, between 1898 and 1925, psychiatry enters the general hospitals of NSW* and in *Chapter Eight: Psychiatry in the doldrums (1925 to 1961)*. Accurate references concerning the data in those chapters are provided as endnotes to those two chapters. In 1898, Dr Eric Sinclair, who was a native of Glasgow and a graduate of the University of Glasgow succeeded Norton Manning as the Inspector-General of the Insane for New South Wales. Sinclair was determined to make it easy for persons who had mental symptoms to gain psychiatric assessment and treatment without any requirement that they should be legally certified as insane. Sinclair ignored the strictures of the Mental Health Act of NSW (1898) and encouraged voluntary admission to his mental hospitals and to a mental ward that was constructed, in 1908, adjacent to the Darlinghurst Reception House. During the Great War, Sinclair encouraged voluntary admission to his military hospitals at Broughton Hall and Callan Park and, in 1921, to the new Broughton Hall Special Hospital. In 1922, Sinclair was instrumental in the creation of a Chair of Psychiatry at the University of Sydney and a Department of Psychiatry at the Royal Prince Alfred Hospital. The first Professor of Psychiatry was Sir John Macpherson. Macpherson had been the Commissioner for Lunacy for Scotland between 1899 and 1921

and was known to be an advocate for general hospital psychiatry. In 1923 Macpherson acquired six beds in the medical wards of RPAH for the diagnosis and treatment of cases of incipient mental disorder and established a substantial psychiatric outpatient clinic at that hospital. Within the next six years psychiatric outpatient clinics appeared in most of the major general hospitals of New South Wales. During Sinclair's tenure, between 1898 and 1925, most of the developments within the mental health services of NSW resembled those in the psychiatric services of Britain, but with modifications which were necessitated by the laws and the practices of the Colony of NSW, and by the geography of that extensive jurisdiction.

During the first quarter of the twentieth century, psychiatrists in NSW were aware of major innovations in the psychiatric services of the USA. For example, they observed the creation of psychopathic wards and pavilions in general hospitals in the USA and noted whether those ventures were successful. Some details concerning the adoption of ideas about psychiatric services from the northern hemisphere are discussed in *Chapter Six: New proposals for a new century*. Accurate references concerning the data in that chapter are provided as endnotes. In 1911, during the Australasian Medical Congress in Sydney, Dr Andrew Davidson, a former medical superintendent of Callan Park Mental Hospital, read a paper written by Dr Montgomery Mosher about the successful functioning of a psychiatric facility annexed to a major general hospital in Albany, New York. Davidson proposed that a similar facility should be built close to RPA Hospital in Sydney.

The second Professor of Psychiatry at the University of Sydney (1927-1951), Dr William S. Dawson, was an Oxford graduate who had been influenced by the ideas of Adolph Meyer when he received postgraduate training in the department of psychiatry at Johns Hopkins

Hospital in Baltimore. During the 1930s, Charlie Hogg, the third Inspector-General of Mental Hospitals for NSW, cited a publication concerning psychopathic hospitals and psychopathic wards in general hospitals in North America when he argued that general hospital psychiatric facilities should be created in New South Wales. The literature review that I performed during the first year of this research project, and on which I reported in *Chapters One and Two* of this dissertation, did not suggest that there were influences on the development of psychiatric services from countries other than the UK and the USA.

The creation, in 1938, of an academic psychiatric inpatient and outpatient facility at RPA Hospital, in the new Psychiatry and Neurosurgery Pavilion, was an important milestone in the history of GHP in NSW. The persons who seem to have been most influential in the creation of this facility included Dr Eric Sinclair, Dr Andrew Davidson and Professor Sir John Macpherson—all of whom were natives of and had been medically trained in Scotland. Their roles in promoting the idea of a general hospital psychiatric facility adjacent to RPAH, and the possible relevance of Dr Mosher's innovation in Albany, NY, were also discussed in *Chapter Six* and *Chapter Seven* of this dissertation.

After 1948 the trajectories of the psychiatric services of Britain and of New South Wales began to diverge. In that year the recently elected Atlee Labour Government introduced the British National Health Service and began to implement new health policies and to assert greater governmental control over hospitals and health services. Thereafter, the British psychiatric services became increasingly focussed on the management of the severest categories of psychiatric disorders. The commonest of those disorders, especially within the psychiatric hospitals, were schizophrenia, manic-depressive illness, dementia and severe personality disorders. These disorders were seldom responsive to the treatments provided by

psychodynamic psychotherapists or by private psychiatrists in office practice or in private hospitals. The latter sectors of psychiatric practice were not destined to flourish in the United Kingdom between 1948 and the 1990s but would be better tolerated and would sometimes be welcomed in the United States and in Australia. After 1948, most of the Australian medical profession, including its psychiatrists, were alarmed by the changes in the health services in the UK and wished to avoid close duplication. In 1949 the Government of Robert Menzies gave assurances to Australian voters, and to the Australian medical profession, that it would avoid measures which were tainted by what political conservatives characterised as 'socialism'. For the next twenty-three years Federal Governments lent significant support to the private practice of general medicine and to the private practice of psychiatry.

In the early 1950s, Prime Minister Menzies became aware of the neglect of mental hospitals by state governments. According to Dr Eric Cunningham Dax, Menzies was aroused to action by a conducted tour of the overcrowded and unsatisfactory conditions in the Kew Mental Asylum.⁴ Menzies' Government ordered an expert assessment of the quality of the psychiatric services throughout Australia. That review led to the Stoller and Arscott Report (1955), which advised a major shake-up of psychiatric services throughout Australia and guaranteed that the Federal Government would become increasingly engaged in mental health issues which had previously been the responsibility of the states and the territories.⁵ The findings and the consequences of the Stoller & Arscott Report are discussed in *Chapter Nine: psychiatry in the doldrums (1925 to 1961)* and *Chapter Ten: a renaissance in psychiatry in New South Wales (1961 to 1994)*. Accurate references concerning the data in those chapters are provided as endnotes to those chapters. The engagement of the Federal Government in mental health issues resembled the scenario in the USA in the late 1940s when the Truman administration began to provide funding for education and research in the

field of mental health and paved the way for greater Federal support for mental health services in that country. Between 1938 and 1955 the advent of new biological treatments for the management of insanity, including pharmacological agents, contributed to a renaissance in psychiatric services throughout the industrialised countries of the world.

During the period under review (1898 to 1961) there is very little to suggest that there were any direct influence on the trajectory of the growth of psychiatric services in NSW from countries other than the UK or the USA. Eric Sinclair, Sir John Macpherson and William Dawson who were natives of Scotland and England. Their psychiatric philosophies and experiences were fundamentally British, but it is noteworthy that Dawson and his academic successor, Trethowan, had post-graduate experiences in the USA.

13.4 Argumentation concerning the third period: 1961 to 1994

The relevant passage within the contention that was recorded in the Introduction to this dissertation reads as follows:

In the late 1950s, the availability of powerful new treatments for severe mental disorders allowed the creation of new policies concerning the management of those disorders. These developments made possible, in 1961, the commencement of the second phase of the era of general hospital psychiatry in NSW, during which acute psychiatric services migrated into the general hospitals. Also during the 1960s, the arrival of new ideas from the United States of America concerning community-focussed psychiatry and consultation-liaison psychiatry fostered major changes in the psychiatric services in NSW.

Between 1948 and 1994 the characteristics of the government funded and the privately funded psychiatric services of New South Wales differed, in significant respects, from their counterparts in the UK and the USA. By 1994 the acute psychiatric services of NSW had effectively subdivided into integrated community-oriented psychiatric services and consultation-liaison services. The mental hospitals had lost most of their acute psychiatric services but had retained some of their other clinical functions. In 1994, psychiatric services in New South Wales were following a trajectory that was determined by local experience and expertise and were developing with far less ongoing influence from beyond the shores of Australia.

After the Second World War, a decade elapsed before the mental hospitals of New South Wales started to emerge from years of neglect and privation. The remarkable transformation of mental health services which commenced in the early 1960s is described in *Chapter Nine: The impact of new treatments on psychiatric services* and in *Chapter Ten: A renaissance in psychiatry in New South Wales (1961 to 1994)*. Accurate references concerning the data in those chapters are provided as endnotes to those chapters. During the 1950s and 1960s several prominent British psychiatrists moved to Australia to occupy important academic and administrative positions. Between 1956 and 1962, William Trethowan made an immense impression on the psychiatric services in NSW but Trethowan did not settle in Australia. Among the permanent migrants were Wallace Ironside, Eric Cunningham Dax, William Cramond and Leslie Kiloh. In 1981, Professor William Cramond published a paper on the influence on Australian psychiatry of psychiatrists who had been educated overseas.⁴ Cramond was a graduate of the University of Aberdeen who moved to Adelaide in 1961 to accept directorship of the mental health services of South Australia. In 1963 he accepted the

foundation Chair of Psychiatry at the University of Adelaide. Cramond noted that thirty-one percent of a large sample of Australian Fellows of the RANZCP had medical qualifications from countries other than Australia or New Zealand. Within Cramond's sample of 354 overseas graduates, sixty percent were from the United Kingdom. Prior to the mid 1960s, most psychiatrists who migrated to Australia were British but subsequent migrants had more often been Indian or South African. Twenty-four of Cramond's sample had (unspecified) European qualifications. Only ten of the overseas graduates in Cramond's sample had North American qualifications. Cramond noted that, in 1980, most of the heads of departments of psychiatry in Australia's ten medical schools had British qualifications but that those numbers were declining. At the two most recently established medical schools, Flinders and Newcastle, the Chairs were Australian graduates. Cramond opined that the contributions of psychiatrists who had migrated from Britain, had been very significant, but added that the psychiatric profession in Australia and New Zealand had 'mongrel' qualities which included sturdiness, intelligence and resilience. His paper concluded 'Certainly we have to become more self-reliant,' and 'Advances in the future will come more from our own resources rather than from further migration of already trained psychiatrists.'⁵

In 1964 the psychiatric profession throughout Australasia was strengthened by the establishment of the Australian and New Zealand College of Psychiatrists (ANZCP). At the outset, David Maddison occupied the powerful position of Censor-in-Chief and was therefore the gatekeeper to Membership and Fellowship of the College. The creation of the ANZCP preceded the formation of the (British) Royal College of Psychiatrists by seven years. In 1964-65 Maddison took sabbatical leave to visit the northern hemisphere. On this occasion, he travelled to Boston to study with the community psychiatrist, Gerald Caplan. There is more about Maddison's career, his philosophy and his influence on the future of Australian

psychiatry in *Chapter Eleven: The impact of psychiatry on medicine: Maddison and Pilowsky*. Accurate references concerning the data in that chapter are provided as endnotes.

In 1960 Issy Pilowsky used sabbatical leave to visit the school of George Engel in Rochester, NY. In 1964-65 Bill Barclay used a Harkness Fellowship to visit several psychiatric centres in the UK and in the USA but particularly to study with Gerald Caplan in Boston. More than a decade later Beverley Raphael also studied with George Caplan. The sources of instruction chosen by those influential Australian psychiatrists demonstrates the priority that they assigned to developments in the biopsychosocial model of illness, preventive psychiatry, community psychiatry and consultation-liaison psychiatry. Their choices also show the importance, in the 1960s and the 1970s of psychiatric innovations in the United States as sources of inspiration for those who wished to improve the psychiatric services of New South Wales.

By 1970 it was becoming evident that Australian psychiatry was starting to develop mental health sub-services, especially in community psychiatry and in consultation-liaison psychiatry, that were at least as ambitious as their counterparts in Britain or in the USA. By 1994 it was evident that those two sub-services were sometimes better established and better supported by Australian governments than those sub-services were supported by governments of the UK or of the USA. Details concerning evidence for the stability of Australian consultation-liaison and of community-oriented psychiatric services are provided in *Chapter Ten: A renaissance in psychiatry in New South Wales (1961 to 1994)* and in *Chapter Twelve: The birth and growth of consultation-liaison psychiatry in New South Wales*. Accurate references concerning the data in those chapters are provided as endnotes to those chapters. Between 1970 and 1994, the mental health services of NSW, and those of the

other Australian states and territories, increased in size and in depth. At the same time, throughout Australia, academic psychiatry and the private practice of psychiatry were growing in substance and in confidence. During that quarter century Australian psychiatry welcomed international ideas but was not greatly dependent on them for its survival and growth. The psychiatric services of all the Australian states and territories freely shared their ideas and their experiences. They sought to learn from the successes and the failures of their sibling mental health services. This was a sign that, by 1994, the mental health services of New South Wales had gained considerable maturity.

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Appendix One

Methodology: How data were discovered and accessed

This appendix offers details about the strategies that I employed to discover data that could prove relevant to the history of general hospital psychiatry in New South Wales. I searched for such data on the internet, in professional journals and books, in an array of written papers and documents, in various archives and libraries, and in my own memory banks and in the memory banks of current and former mental health professionals. In this appendix these resources are discussed in the following order: research strategies that utilised the internet, research strategies that utilised collections of published documents, and research strategies that utilised memory banks.

Research strategies that utilised the internet

My internet searches were conducted in three phases. In each phase I had a specific goal.

During Phase One of the internet searches, I sought to discover titles and abstracts that were concerned with general hospital psychiatry or with the history of general hospital psychiatry.

To avoid missing titles that might be relevant to my subject, I employed three separate internet search engines: The Catalogue of the Fisher Library of the University of Sydney, Medline Ovid, and Google Scholar. By using three separate search engines I hoped to capture material that had been collected by a variety of scholarly disciplines, including those devoted to history, to psychiatry and to general medicine.

During Phase Two of the internet searches, I used the internet to search for titles and abstracts concerning the history of psychiatry in New South Wales and the history of psychiatry in other parts of Australia.

During Phase Three of the internet searches, I looked for titles concerning the history of medical administration in New South Wales and medical administration in Australia.

I performed these searches in 2015 and repeated them in 2019 to check for errors and to identify data that had been published between 2015 and 2019.

Phase One Results (which concerned ‘general hospital psychiatry’ globally)

First Search: Fisher Library Catalogue (Everything): Results: I identified over 1,600 titles in response to the keyword ‘*general hospital psychiatry*’, but in the first hundred hits, there were only three journal articles and two books that had titles which suggested relevance to the history of general hospital psychiatry. I gave each of these five titles a Selection Number. As my internet searches progressed it was inevitable that titles would be duplicated. I did not assign a Selection Number to any duplicates. The identified titles were as follows:

1. Mayou R. (1989) The history of general hospital psychiatry. *British Journal of Psychiatry* 155: 646-676. (Selection 1)
2. Lebensohn ZM. (1980) ‘General Hospital Psychiatry U.S.A.: Retrospect and Prospect’. *Comprehensive Psychiatry*, Vol.21 (6), 500-509. (Selection 2)
3. Summergrad, P, Hackett, TP. (1989) Alan Gregg and the rise of general hospital psychiatry. *General Hospital Psychiatry*. 9: 439-445. (Selection 3)
4. Stern TA, Freudenreich O, Smith FA, Fricchione GL, Roseau JF. Editors. (2017) *The Massachusetts General Hospital Handbook of General Hospital Psychiatry*. 7th Edition. New York. Elsevier. (Selection 4)
5. Bandler, B (Ed) (1966) *Psychiatry in the general hospital*. London: J. & A. Churchill Ltd. (Selection 5)

Second Search: Fisher Library Catalogue Collections: During this search, I again used the Fisher Library Catalogue Collections (Everything), but I now employed the keyword ‘*history of general hospital psychiatry*.’ This gave ten results. Of these, three titles were not relevant to the history of general hospital psychiatry and were immediately discarded. The seven

results of possible relevance were five books and two professional journals. The five books were:

1. Stern TA, Freudenreich O, Smith FA, Fricchione GL, Rosenbaum JF. Editors. (2017) Duplicate of 4.
2. Linn L. Editor, (1961) *Frontiers of General Hospital Psychiatry*. New York. International Universities Press Inc. (Selection 6)
3. Taylor MA, Sierles F, Abrams R. (1985) *General hospital psychiatry*. London Collier Macmillan. (Selection 7)
4. Burrows GD, Lipsitt RD, Judd FK (1991) *Handbook of studies on general hospital psychiatry*. Amsterdam. Elsevier. (Selection 8)
5. Lloyd GG (1991) *Textbook of general hospital psychiatry*. London Churchill Livingstone. (Selection 9)

Comment: The book by Burrows, Judd and Lipsitt appeared to be relevant because Burrows and Judd are Australian academic psychiatrists and Lipsitt is a well-known American psychiatrist-historian who has a special interest in general hospital psychiatry. However, this book proved to be an assortment of chapters, none of which contained data of relevance to the history of GHP in Australia. The other book, by Lloyd, might be relevant. Lloyd was a British academic psychiatrist who later joined with the academic psychiatrist, Else Guthrie, to co-edit volumes of what became the *Handbook of Liaison Psychiatry* (2007).

The two professional psychiatric journals were: *Annals of General Hospital Psychiatry*. BioMed Central Ltd. 2002-2004 and *General Hospital Psychiatry* (1979 to the present day).

Comment: The journal *Annals of General Hospital Psychiatry* would later become the *Annals of General Psychiatry* and would lose its focus on general hospital psychiatry as a specialty area. The journal '*General Hospital Psychiatry*' was the first periodic professional journal to have the phrase 'general hospital psychiatry' in its title. It was launched in 1979, with an

introductory editorial by Donald Lipsitt. Many papers published in this journal are relevant to the history of GHP.

Third Search: Medline via Ovid (1946-present):

Responses to a search using Medline via Ovid (1946-present) (limited search) employed the keyword '*history of general hospital psychiatry*'. This search produced only two titles, both relating to journal articles, one of which was a duplicate.

Mayou R. (1989) Duplicate of 1.

Greenhill MH. (1979) Psychiatric units in general hospitals. *Hospital and Community Psychiatry*. 30. 169-182. (Selection 10)

Fourth Search: Medline via Ovid SP (1946-present): Responses to a search using Medline via Ovid employed the keywords '*general hospital psychiatry*' together with '*history*' produced 28 hits, which included 16 listed as {Historical Article}. 11 of these 16 articles were chosen as relevant, but two were duplicates of previously identified titles:

Freeman HL. The general hospital and mental health care: a British perspective. *Milbank Quarterly*. 73 (4):653-76, 1995. {Historical Article. Journal Article} (Selection 11)

Walkup J. (1994). The early case for caring for the insane in general hospitals. *Hospital & Community Psychiatry*. 45 (12):1224-8. (Selection 12)

Lipowski ZJ. (1992) Consultation-liaison psychiatry at century's end. *Psychosomatics*. 33(2):128-33. (Selection 13)

Huyse FJ. (1991) Consultation-liaison psychiatry: Does it help to get organized? The European Consultation-Liaison Workgroup. *General Hospital Psychiatry*. 13 (3):183-7. (Selection 14)

Mayou R. (1989) Duplicate of 1.

Pasnau RO. (1982) Consultation-liaison psychiatry at the crossroads: in search of a definition for the 1980s. *Hospital & Community Psychiatry*. 33(12): 989-95 (Selection 15)

Keill SL. (1981) Introduction: The evolution of psychiatry in the general hospital. *General Hospital Psychiatry*. Vol.3(4), 289-291 (Selection 16)

Lipowski ZJ. (1981) Holistic foundations of consultation-liaison psychiatry in the USA. *American Journal of Psychiatry*. 138(7):888-95 (Selection 17)

Greenhill MH. (1979) Duplicate of 10.

Jones RE. (1979) Issues facing general-hospital psychiatry: introduction: the birth of a new subspecialty. *Hospital & Community Psychiatry*. 30(3):183-4 (Selection 18)

Richman A; Harris P. General hospital psychiatry: are its roles adjunctive or pivotal? *General Hospital Psychiatry*. 7(3): 258-66, (Selection 19)

Fifth Search: Medline via Ovid (1946-present): Responses to an internet search using

Medline via Ovid SP that employed the keyword '*general hospital psychiatry*'.

This search located 97 titles of journal articles published between 1963 and 2019. Between 1963 and 1980 there were 18 titles; between 1981 and 1990 there were 36; between 1991 and 2000 there were 21; from 2001 to 2010 there were 14; since 2010 there have only been 3.

The decline in journal articles with titles that included the phrase '*general hospital psychiatry*' between 1960 and 2000 is relevant to the present dissertation because it suggests that the phrase '*general hospital psychiatry*' is becoming obsolete. If so, this is probably because, by 2000, most acute psychiatric services had moved from the mental hospitals. In other words, there was no need for '*general hospital*' as a grammatical qualifier ahead of '*psychiatry*' because most acute psychiatric services had moved out of the mental hospitals and into general hospitals and into the communities that the general hospitals served. The obsolescence of the term '*general hospital psychiatry*' might also have occurred because general hospital psychiatric services had subdivided into community-oriented psychiatric services and consultation-liaison psychiatric services.

Examination of all titles suggested that 24 of those articles might refer to historical issues, but only 14 had an appended notation: {Historical Article}. Some of these articles were obituaries and others were about historical developments in small non-English speaking countries. The removal of papers that seemed to lack relevance to the history of general hospital psychiatry left the following seventeen journal articles that might be relevant to the current research project:

Freeman HL. (1995) Duplicate of 11.

Walkup J. (1994) Duplicate of 12.

Mai FM. (1966) General Hospital Psychiatry: Data Analysis of a Unit. *Medical Journal of Australia*. 2(21): 986-91. (Selection 20)

Comment: Dr FM Mai was an Australian author. The paper is published in the *MJA*. It is probably relevant to this research project.

Whitehead JA. (1971) Towards General-Hospital Psychiatry. letter *Lancet* 2 (7732):1037. (Selection 21)

Jones RE. (1979) Duplicate of 18.

Greenhill MH. (1979) Duplicate of 10.

Lebhenson ZM. (1980) Duplicate of 2.

Lipowski ZJ. (1981) Duplicate of 17.

Keill SL. (1981) Duplicate of 16.

Bachrach LL. (1981) The effects of deinstitutionalization on general hospital psychiatry. *Hospital & Community Psychiatry*. 32(11):786-90. (Selection 22)

Richman A; Harris P. (1985) Duplicate of 19.

Summergrad P; Hackett TP. (1987) Duplicate of 3.

Mayou R. (1989) Duplicate of 1.

Lipowski ZJ. (1992) Duplicate of 15.

Lipsitt DR. (1999) General hospital psychiatry in the 21st century: will old acquaintance be forgot? *General Hospital Psychiatry*. 21(1):1-2. {Editorial} (Selection 23)

Udo I; Odeyale F; Gash A; Fossey M. (2016) The rise of liaison psychiatry: challenges and implications for sustainability. *British Journal of Hospital Medicine*. 77(9): 523-8. (Selection 24)

Lipsitt DR. (2003) Psychiatry and the general hospital in an age of uncertainty. *World Psychiatry*. 2(2): 87-92. (Selection 25)

Sixth Search: Google Scholar: Responses to a Google Scholar search employing the keyword 'history of general hospital psychiatry'. Within the first hundred 'hits' this search discovered 14 titles that might be relevant to this research project. Most of those titles were duplicates of previous Medline via Ovid searches, leaving eight new hits:

Mayou R. (1989) Duplicate of 1.

Lipsitt DR. (2003) Duplicate of 25.

Summergrad P; Hackett TP. (1987) Duplicate of 3.

Friedman RS, Molay F. (1994) A history of psychiatric consultation in America. *Psychiatric Clinics*. 17: 3: 667-681. (Selection 26)

Stern TA and others. (2018) Duplicate of 4.

Mayou R, F Huyse F. (1991) Consultation-liaison psychiatry in Western Europe, ECL Workgroup. *General hospital psychiatry*. 188-208. (Selection 27)

Novella EJ (2010) Mental health care in the aftermath of deinstitutionalization: a retrospective and prospective view. *Health Care Analysis* 18, 222-238 (Selection 28)

Freeman HL (1995). Duplicate of 11.

Freeman HL (1996) The evolution of community psychiatry in Britain in Breakey WR (Editor) *Integrated Mental Health Services: Modern Community Psychiatry* Oxford. Oxford University Press. 53-68. (Selection 29)

Lloyd GG (1991) *Textbook of general hospital psychiatry*. London. Churchill Livingstone. (Selection 30)

Hackett TP and others (2010) Beginnings: Psychosomatic Medicine and Consultation Psychiatry in *Massachusetts General Hospital Handbook of Consultation-Liaison Psychiatry*. Elsevier. New York. (Selection 31)

Greenhill MH. (1979) Duplicate of 10.

Akagi H, House A (2007) *Psychiatry in the general hospital* in *Seminars in General Adult Psychiatry*, London. Royal College of Psychiatrists. (Selection 32)

Burge R (2016) *Callan Park in Transition* in Kritsotaki D, Long V, Smith M. (2016) *Deinstitutionalisation and After: Post-War Psychiatry in the Western World*. Cham. Springer International Publishing. (Selection 33)

Comment concerning Selection 33: it contains a chapter by an Australian historian, Roslyn Burge concerning the closure of Callan Park/Rozelle Mental Hospital in Sydney. It may be relevant and is retained for examination.

Comment on completion of the above (Phase One) of my internet searches:

After sifting through all the titles that were discovered during these six internet searches, and having removed all duplicates, I examined the related abstracts and sometimes examined the full articles before deciding which titles should be eliminated from further study. This process whittled the number of titles to 33. These titles appear in the References attached to the end of this appendix and are listed as Selections 1 to Selection 33. Following an

examination of the above books, chapters and journal articles—Selection 1 to Selection 33—I drew the following tentative conclusions:

1. The 1989 paper from the UK by Mayou (Selection 1) titled ‘The History of General Hospital Psychiatry’ was identified by four of the searches, had numerous citations and was clearly very relevant to the current research project.
2. The book Stern TA and others (2017) *The Massachusetts General Hospital Handbook of General Hospital Psychiatry*. 7th Edition. (Selection 4) was frequently identified by searches, was cited on many occasions, and therefore deserved attention.
3. Three of the searches found several papers from the USA by Donald R Lipsitt. These attracted many citations, which suggested that Lipsitt’s writings should be explored.
4. Two searches found papers from the USA by Z J Lipowski. These were often cited. They deserve attention.
5. None of the searches discovered any titles that suggested that any of those books, chapters or journal articles contained a narrative account of the history of GHP in New South Wales or in other parts of Australasia.
6. The searches only discovered one paper with a title that implied direct relevance to GHP in Australia ... the paper by FM Mai published in 1966 in the *MJA* (Selection 20).

Phase Two Results (which concerned ‘general hospital psychiatry’ in New South Wales or in other parts of Australia)

To identify publications of relevance to psychiatry in New South Wales or elsewhere in Australia, I employed the keywords ‘Australia’ and ‘New South Wales’ in Phase Two of my internet searches.

Seventh Search: Results of a Google Scholar search that added two keywords 'history of psychiatry' and 'Australia':

In the first 100 'hits' there were 19 titles of apparent relevance. (See References list at the end of this chapter as numbered Selections). These 19 titles were:

Kirkby KC. (1999) History of psychiatry in Australia pre-1960. *History of Psychiatry*. 10 (38 Pt 2):191-204 (Selection 34)

Smith GC, Clarke DM, Herrman HE. (1993) Consultation-liaison Psychiatry in Australia. *General Hospital Psychiatry*. 15: 121-124. (Selection 35)

Coleborne C, MacKinnon D (2006). Psychiatry and its institutions in Australia and New Zealand: An overview. *International Review of Psychiatry*. 14.:4. 371-380. (Selection 36)

MacKinnon D, Coleborne C. (2003) Introduction: Deinstitutionalisation in Australia and New Zealand. *Health and History*. vol 5 No 2. 1-16. (Selection 37)

Dax EC (1992) The evolution of community psychiatry. *Australian & New Zealand Journal of Psychiatry*. 295-301 (Selection 38)

Bell M. (2003) From the 1870s to the 1970s: the changing face of public psychiatry in South Australia. *Australasian Psychiatry*. 79-86 (Selection 39)

Dax EC (1989) The first two hundred years of Australian Psychiatry. *Australian and New Zealand Journal of Psychiatry*. 23. 1. 103-110. (Selection 40)

Parkinson JP (1981) The Castle Hill Lunatic Asylum 1811-1826 and the origins of eclectic pragmatism in Australian Psychiatry. *Australian and New Zealand Journal of Psychiatry*. 15: 319-322 (Selection 41).

Bynum WF, Porter R (1994) *Companion encyclopedia of the history of medicine*. Oxfordshire. Routledge. (Selection 42).

Dax EC (1975) *Australia and New Zealand* in Howells JG. *The World History of Psychiatry*. London. Ballière Tindall.704-728 (Selection 43)

Lipton GL (1983) Politics of mental health: circles or spirals. *Australian and New Zealand Journal of Psychiatry*. 17: 1. 50-56. (Selection 44)

Coleborne C. (2006) Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, c. 1880–1910. *Social History of Medicine* 19: 3: 425-442 (Selection 45)

Duke M (2007) The dawn of aboriginal psychiatry *Australasian Psychiatry*, 15: 4: 305-309. (Selection 46)

Robson B (2002) An English psychiatrist in Australia: memories of Eric Cunningham Dax and the Victorian Mental Hygiene Authority, 1951-1969. *History of Psychiatry*. 69-78 (Selection 47)

Colborne C. (2017) Making 'mad' populations in settler colonies: The work of law and medicine in the creation of the colonial asylum, in *Law, history, colonialism*. Manchester. Manchester University Press. (Selection 48)

Colborne C. (2009) Families, insanity and the psychiatric institutions in Australia and New Zealand. 1860-1914 *Health and history*. 68-92 (Selection 49)

Schwarz S (2010) The regulation of British colonial lunatic asylums and the origins of colonial psychiatry, 1860–1864. *History of Psychology* 13: 2: 160-177 (Selection 50)

Coleborne C, MacKinnon D (2006). Psychiatry and its institutions in Australia and New Zealand: An overview. *International Review of Psychiatry*. 14:4. 371-380. (Selection 51)

Bostock J (1951) *The Dawn of Australian Psychiatry*. Glebe. Australian Medical Publishing Company. (Selection 52)

Eighth Search: Results of a Google Scholar search adding together two keywords 'history of psychiatry' and 'New South Wales': this search discovered the following fifteen titles:

Garton S (1986) Sir Charles Mackellar: psychiatry, eugenics and child welfare in New South Wales, 1900–1914. *Australian Historical Studies* 21-34 (Selection 53)

Colborne C (2006) "His Brain was Wrong, His Mind Astray": Families and the Language of Insanity in New South Wales, Queensland, and New Zealand, 1880s-1910. *Journal of Family History*. 31: 1: 45-65 (Selection 54)

Sands NM (2009) Round the bend: A brief history of mental health nursing in Victoria. *Issues in mental health nursing*. 364-371 (Selection 55)

Shea P (2001) One hundred years ago in New South Wales. *Australasian Psychiatry*. 9: 1: 29-33. (Selection 56)

Garton S. (1986) The rise of the therapeutic state: Psychiatry and the system of criminal jurisdiction in New South Wales, 1890–1940. *Australian Journal of Politics & History* 32: 3: 378-388. (Selection 57)

Cummins CJ. (2003) 2nd Edition *A history of medical administration in New South Wales 1788-1973*. Sydney. Health Commission of New South Wales. (Selection 58)

Lipton GL (1983) Duplicate of 44.

Edwards GA (1982) Causation of insanity in nineteenth century Australia. *Australian and New Zealand Journal of Psychiatry*. 61: 1: 53-62 (Selection 59)

Gillespie JA (2002) *The price of health: Australian governments and medical politics 1910-1960*. Cambridge. Cambridge University Press. (Selection 60).

Garton S. (1991) The 'tyranny' of doctors: The citizen's liberty league in New South Wales, 1920–39. *Australian Historical Studies* 340-358. (Selection 61)

Lipton GL (1983) Duplicate of 44.

Hunter E (2007) Disadvantage and discontent: A review of issues relevant to the mental health of rural and remote Indigenous Australians. *Australian Journal of Rural Health*. 88-93 (Selection 62).

Smith GC, Clarke DM, Herrman HE. (1993) Duplicate of 35.

Bell M. (2003) Duplicate of 39.

Bynum WF, Porter R (1994) Duplicate of 42.

Comments about titles identified during Phase Two of internet searches concerning the history of psychiatry in New South Wales or in Australia: Selection 34 to Selection 62:

1. Review of the 'hit' titles or of their abstracts suggested that none of those articles had a focus on general hospital psychiatry in New South Wales or on the history of general hospital psychiatry in New South Wales.
2. A title that suggested great relevance to GHP in NSW: Cummins CJ. (2003) 2nd Edition *A history of medical administration in New South Wales 1788-1973*. Sydney. Health Commission of New South Wales. (Selection 58).
3. A title that appeared very relevant to GHP in Australia was Smith GC, Clarke DM, Herrman HE. (1993) Consultation-liaison Psychiatry in Australia. *General Hospital Psychiatry*. 15: 121-124. (Selection 35).

There were four titles of uncertain but possible relevance to GHP in New South Wales. These were:

MacKinnon D, Coleborne C. (2003) Introduction: Deinstitutionalisation in Australia and New Zealand. *Health and History*. vol 5 No 2. 1-16. (Selection 37)

Dax EC (1975) Australia and New Zealand in Howells JG *World History of Psychiatry*. London. Ballière, Tindall. (Selection 43)

Dax EC (1989). The first two hundred years of Australian Psychiatry. *Australian and New Zealand Journal of Psychiatry*. 23. 1. 103-110 (Selection 40)

Dax EC (1992) The evolution of community psychiatry. *Australian & New Zealand Journal of Psychiatry*. 295-301 (Selection 38)

Phase Three of internet searches: The history of medical administration in NSW and in Australia

To gain an understanding of the social, economic, political and administrative factors that influenced the development of general hospital psychiatry and general medicine in New South Wales it was necessary to create a brief but reliable overview of the history of medical administration in New South Wales. I therefore conducted Google Scholar searches by employing the keywords '*history of medical administration*' together with '*New South Wales*' and then together with '*Australia*'.

Ninth Search: Results of Google Scholar search: keywords '*history of medical administration*' and '*New South Wales*'. There were four hits:

Lewis M, McLeod R (1988) Medical politics and the professionalisation of medicine in New South Wales, 1850–1901. *Journal of Australian Studies*. 69-82 (Selection 63)

Garton S. (1986) (Duplicate of 57)

Edwards GA (1982) Causation of insanity in nineteenth century Australia. *Australian and New Zealand Journal of Psychiatry*. 61: 1: 53-62 (Selection 64)

Tyler PJ. (2006) *The Administration of New South Wales. Volume 2 (2006), 'Humble and Obedient Servants, 1901 to 1960*. Sydney. University of New South Wales. (Selection 65)

Tenth Search: Results of Google Scholar search: keywords '*history of medical administration*' and '*Australia*': This search produced 34 titles. Most of the titles did not appear relevant to the medical administration of NSW or were duplicates of the previous searches. There were only two newly identified titles of interest:

Shea P. (1999) *Defining Madness*. Leichhardt NSW. The Federation Press. (Selection 66)

Lewis MJ (2003) *The Peoples Health: Public health in Australia from 1788 to 1950*. Westwood CT Greenwood Publishing Group. (Selection 67)

Eleventh Search: Results of Google Scholar search employing the keywords '*history of medicine*' together with '*New South Wales*'. In the first one hundred 'hits' the only titles that appeared to be relevant amounted to ten. These were:

Hunter E (2007) Duplicate of 62.

Bynum WF, Porter R (1994) Duplicate of 42.

Colborne C (2006) Duplicate of 54.

Colborne C. (2017) Duplicate of 48.

Wright D (1997) Getting out of the asylum. Understanding the confinement of the insane in the nineteenth century, *Social history of medicine*:10:1: 137-155 (Selection 68)

Dax EC (1989) Duplicate of 40

Lloyd P (1994) A history of medical professionalisation in NSW: 1788/1950. *Australian Health Review*. 17:2:14-28. (Selection 69)

Coleborne C, MacKinnon D (2006). Duplicate of 36.

Hunter E (2007) Duplicate of 62.

Coleborne C. (2006) Duplicate of 45.

Comments on the results of the above (Third Phase) internet searches relating to ‘medical administration’, ‘New South Wales’ and ‘Australia’: Selection 63 to Selection 69:

1. The monograph ‘A history of medical administration in New South Wales, 1788-1973’ by CJ Cummins (2003) (Selection 58) was a title that suggested great relevance. It was frequently cited. Cummins was the Director-General of Public Health from 1959 to 1975 and for many of the later years had a major role in reorganising the psychiatric services of New South Wales.
2. Two other papers that appeared to be relevant were:

Lewis M, McLeod R (1988) Medical politics and the professionalisation of medicine in New South Wales, 1850–1901. *Journal of Australian Studies*. 69-82. (Selection 63) and

Lloyd P (1994) A history of medical professionalisation in NSW: 1788/1950. *Australian Health Review*. 17:2:14-28. (Selection 69)

3. Publications by Milton J Lewis appeared several times in my internet searches concerning Australia and deserved attention.
4. The paper by Catherine Colborne and Dolly Mackinnon in 2006 titled ‘Psychiatry and its institutions in Australia and New Zealand: An Overview’ (Selection 51) was

identified by most searches and might be relevant. However, it did not seem to be focussed on general hospital psychiatry.

5. The book by Peter Tyler: *Humble and Obedient Servants: The Administration of New South Wales. Volume 2. 1901-1960* (Selection 65) appeared to be relevant to medical administration in NSW.

When I had completed all three phases of my internet searching, I realised that those searches had failed to identify some titles that I could recall reading that were certainly relevant to the history of psychiatry in New South Wales. Those titles will be discussed later in this chapter under the heading 'Research strategies that utilised memory banks'.

Research strategies that utilised collections of published documents lodged in libraries and archives

Most of the data relevant to this research project are recorded on the pages of books, journals, theses, professional reports, letters, newspaper reports, newspaper clippings and other papers and that are held in various libraries and archives in New South Wales and in the Australian Capital Territory. The main libraries used during this research project were: The State Library of NSW in Macquarie Street, Sydney; the Fisher Library at the University of Sydney, the Library of the University of New South Wales, the Mental Health Library at Concord Hospital, the Australian College of Nursing Library at Parramatta and the Susman Library at the Royal Prince Alfred Hospital.

In March 2015, at the commencement of this research project, I was aware that the Annual Reports of the Inspectors-General of Mental Hospitals for New South Wales and the Annual Reports of their successors, the Directors of the mental health services of New South Wales would contain data of immense importance to this project. Most of those Annual Reports that

were published before 1959 are held at the State Library of New South Wales. After 1959, the accounts of the activities of the mental health service of New South Wales are incorporated in the Annual Reports of NSW Health which are held at the Mental Health Division of the Ministry of Health for New South Wales at North Sydney. Some of the more recent Annual Reports can also be found online at the website of Health New South Wales.

Various archives and museums contained documents of great relevance to this project. They included the Archives and Museum at the Royal Prince Alfred Hospital, the Archives of the University of Sydney and the New South Wales State Government Archives at Kingswood, NSW. The Archives and Museum of the Royal Prince Alfred Hospital was of particular interest as it holds many issues of the in-house hospital newsletters/journals called 'R.P.A.' and 'The RPA Gazette'. It also holds several books that describe aspects of the history of RPA Hospital. It also holds newspaper and magazine clippings of relevance to RPA Hospital. Memoranda, monographs or letters written by psychiatric administrators or by psychiatrists were often identified in journal articles and books that could be examined at the New South Wales State Archives at Kingswood.

Research strategies that utilised the memory banks of the author and of professional colleagues

I had accumulated memories while working as a medical student, as a medical officer at general hospitals, as a trainee psychiatrist at mental hospitals and general hospitals and as a consultant psychiatrist in mental hospitals, general hospitals and community settings. I was able to recall several important papers about the history of psychiatry in New South Wales that had not been identified during my internet searches. These were:

Garton S (1988) *Medicine and Madness. A Social History of Insanity in New South Wales. 1880 to 1940*. Kensington. New South Wales University Press. (Selection 70)

Garton S. (1982) *Mad or Bad? Developments in incarceration in NSW 1880-1920 in What Rough Beast?* Sydney Labour History Group. North Sydney, George Allen and Unwin (Selection 71)

Garton S. (1987) 'Changing Minds' in Curthoys A, Martin A, Rowse T. *Australians—from 1939*. Broadway, NSW. Academy of Social Sciences in Australia. 343-355. (Selection 72).

In addition to those recollections, I knew where documents that contained useful historical data might be lodged. I had worked as a consultant psychiatrist at the Royal Prince Alfred Hospital between 1979 and 2013 and had held administrative positions in the Psychiatry Department at RPAH. For more than three decades I had access to contemporary and to historical documents at RPA Hospital. Those documents would prove to be valuable as sources of historical data.

My relationships with professional colleagues, many of whom were friends or social acquaintances, also gave me access to valuable historical data. Those communications were sometimes face-to-face but were often by telephone or via the internet. Between March 2015 and April 2022, I had many communications with colleagues in which we discussed events and issues in the history of psychiatry in New South Wales. It was easy to question colleagues about events, to clarify details about past events, or to discuss issues that had affected the psychiatric service in which we had both worked. A good example of the value of professional relationships was my friendship with two senior psychiatrist-administrators, Dr Peter Shea and Dr Graham Edwards. They had prepared a monograph about the contributions of Dr Frederick Norton Manning to psychiatry in NSW between 1867 and 1898 but had not been able to find a publisher. They gave me a copy of that monograph and discussed its contents with me. The monograph contained many important historical data and signposted further avenues of historical research. Here is that reference:

Edwards GA. Shea PB. Copyright (2012) *Dr Manning and the Hospitals for the Insane*. Unpublished Monograph in the possession of the present author. (Selection 73)

Summary of Appendix One: Methodology

This appendix describes the methods that were employed to identify documents that could contain information of potential relevance to the history of general hospital psychiatry. By these methods seventy-three journal articles, chapters, monographs and books were identified as potentially relevant. The next step in this research project was to examine the Selections References and to decide which of the data in them should be employed for either of two purposes: to provide the basis for a narrative account of the developmental history of general hospital psychiatry in New South Wales, or to provide evidence that might be used to defend, or to modify, the contention that was stated in the Introduction to this dissertation.

Appendix Two

CURRICULUM VITAE

Name: Richard Trathen White

Home Address: 34 The Avenue, Balmain East, NSW 2041

Currently (May 2022) PhD candidate in the School for the History and Philosophy of Science, University of Sydney

Honorary Associate, Discipline of Psychiatry, Central Clinical School, University of Sydney

Fellow: Royal Australian and New Zealand College of Psychiatrists

Member: Royal College of Psychiatrists (UK)

Member: Australian and New Zealand Society for the History of Medicine

Resignation and Retirement

In 2013 I resigned my appointments as a Senior Staff Psychiatrist at the Royal Prince Alfred Hospital and as a Clinical Senior Lecturer in Psychiatry at the University of Sydney.

In September 2017 I retired from all Australian psychiatric and other medical practice.

Professional Qualifications

MB.BS., University of Sydney (1966)

DPM. (R.C.P.& S; London & Edinburgh) (1970)

MRCPsych. (1972)

MRANZCP. (1978)

FRANZCP. (1979)

MMHumanities, University of Sydney (2008)

Previous Appointments

- 1966 Junior Resident Medical Officer, St Vincents Hospital, Sydney
- 1967 Medical Officer, Kainantu & Kundiawa, Papua and New Guinea
- 1968 Senior House Officer, Psychiatry, Netherne Hospital, Surrey (UK)
- 1969-70 Psychiatry Registrar, Friern Hospital, London N 11. Honorary Clinical Assistant, Royal Free Hospital & Whittington Hospitals London.
- 1970 Specialist Psychiatrist, Newcastle Psychiatric Centre. (September 1970 to March 1971)
- 1971-72 Acting Psychiatrist-in-charge, Psychiatric Research Unit, Rozelle.
Clinical Tutor in Psychiatry, University of New South Wales. April 1971 to March 1973
Consultant Psychiatrist, Ward 13, Callan Park Hospital and Waverley Community Clinic from March 1973
- 1974 Psychiatrist-in-charge, Ward 24, Rozelle Hospital.
Clinical Supervisor in Psychiatry at the University of Sydney.
+ Northside Clinic--Saturday mornings--private practice.
- 1975-78 Staff Specialist Psychiatrist, Sydney Hospital.
Clinical Lecturer in Psychiatry at the University of Sydney.
Private practice: Macquarie Street, Sydney & the Hale Clinic, Mosman.
- 1979-81 Visiting Medical Officer, Sydney Hospital & Royal Prince Alfred Hospital.
Clinical Lecturer in Psychiatry at the University of Sydney (initially a Conjoint Appointment).
Honorary Psychiatrist, St Luke's Hospital, Sydney
- 1981- 1986 Senior Staff Specialist Psychiatrist, Consultation/Liaison Unit and OPD Clinic at Royal Prince Alfred Hospital from March 1981.
- 1987 - 1990 Director Consultation/Liaison Service
Royal Prince Alfred Hospital
Clinical Lecturer, University of Sydney
- 1990 – 1996 Clinical Director of Psychiatry and Acting Director of Psychiatry
Royal Prince Alfred Hospital
Clinical Senior Lecturer, University of Sydney (from 1994).
- 1995-1996 Director of Psychiatry until July 1966 Royal Prince Alfred Hospital.
Clinical Senior Lecturer, University of Sydney
- 1997-2013 Senior Staff Psychiatrist, Royal Prince Alfred Hospital
Clinical Senior Lecturer, University of Sydney.
Chairman, Medical Staff Council – Mental Health for SSWAHS, which became Central Sydney Area Health Service.

Activities following resignation from RPA Hospital in October 2013

From January 2014: Honorary Associate, Discipline of Psychiatry, Central Clinical School, University of Sydney.

From March 2015: Enrolled in PhD studies Unit for the History and Philosophy of Science, University of Sydney.

Locum tenens VMO Psychiatrist Broken Hill Far West Local Health District December 5-9, 2014.

Locum tenens VMO Psychiatrist 2015 Western LHD (Orange).

Roles within the Royal Australian and New Zealand College of Psychiatrists

At the time of resignation from RPA Hospital (October 2013):

Chair, Bi-national Committee History and Philosophy and Psychiatry Special Interest Group until 28/8/2013.

Member of Sections of Consultation-Liaison Psychiatry and of Psychotherapy.

Formerly:

Member, Continuing Education Committee, NSW Branch: (1982 –1989)

Treasurer, Section of Psychotherapy (1994-1996)

Secretary, Section of Psychotherapy (1994-1996) (Treasurer in 1988 and 1989)

Member Australian and New Zealand Association of Psychotherapy. 1989-1999.

Secretary, Interpersonal Psychotherapy Interest Group (1999 - 2003)

Editor: NSW Branch Newsletter: of RANZCP: 2007-2011

Member, NSW State Branch Committee - NSW (2002-2010)

Secretary, Binational Committee History and Philosophy and Psychiatry Special Interest Group for about 10 years

General Councillor Bi-national Royal Australian and New Zealand College of Psychiatrists (from May 2009 – May 2011).

Presentations at Professional Meetings

1988: RANZCP CME Meeting, Sydney Opera House. Oral presentation: "Psychotherapy and the General Psychiatrist."

1989: World Psychiatric Association Congress, Athens. Oral presentation and Chair of session: "Variables in Disliked Medical Patients" (with C Tennant)

1989: Australian Sleep Research Association 2nd Annual General Meeting, Melbourne. Oral presentation "The Liaison Psychiatrist in the Sleep Service".

1996: RANZCP. Annual Meeting, Wellington, N.Z Oral presentation. 'A Reasonable Stance Regarding Long Term Psychotherapy for Borderline Personality Disorder'.

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Appendix Three

Professional Memoir

Introduction

This memoir deals with my life in medicine and in psychiatry. The first reason for including a professional memoir as an appendix to this dissertation is that it might be used to confirm, complement and supplement data which were obtained by conventional scholarship. The second reason for its inclusion, and for the inclusion of my curriculum vitae, is to offer information about myself to any reader who wishes to examine factors that might have affected my perspective of the events that I have described or might influence my argumentation in defence of the contention which I stated in the Introduction to this dissertation.

I was born in Sydney in 1940 and graduated from the Faculty of Medicine at the University of Sydney in January 1966. Between 1968 and 1970 I trained in psychiatry in psychiatric hospitals in Britain. I then returned to Sydney and became a consultant psychiatrist in the mental health service of New South Wales. In all, I completed seven years of professional experience in psychiatric hospitals in Britain and in New South Wales before, in 1975, I was appointed as a staff specialist psychiatrist at Sydney Hospital. Between 1978 and 1981 I split my time between private practice and in visiting medical officer appointments in consultation-liaison psychiatry at Sydney Hospital and at RPA Hospital. Between 1981 and 2013 I held an appointment as a staff specialist psychiatrist at RPA Hospital. For most of those thirty-two years at RPAH my main clinical engagement was in consultation-liaison psychiatry. For six of those years I was either the Acting Director or the Director of

Psychiatry. I retired from my appointment at RPA Hospital in 2013 and gave up my medical registration in 2017.

It might be useful to think of this memoir as an exercise in autoethnography. Carolyn Ellis (2004) defined autoethnography as ‘research, writing, story, and method that connect the autobiographical and personal to the cultural, social, and political’.¹ Adams, Jones and Ellis (2015) added the following comments about the nature of autoethnography:

Autoethnography is a research method that:

Uses a researcher’s personal experience to describe and critique cultural beliefs, practices, and experiences.

Acknowledges and values a researcher’s relationships with others.

Uses deep and personal reflexion—typically referred to as “reflexivity”—to name and interrogate the intersections between self and society, the specific and the general, the personal and the political.

Shows “people in the process of figuring out what to do, how to live, and the meaning of their struggles”.

Balances intellectual, and methodological rigor, emotion and creativity.

Strives for social justice and to make lives better.²

The last criterion: ‘Strives for social justice and to make lives better’ exceeds my ambitions and sounds a little grandiose but I should leave it to the reader to judge whether this memoir meets the criteria of autoethnography that are listed by Adams, Jones and Ellis.

Many years ago, I read the autobiographies of two of my predecessors in psychiatry in New South Wales, Dr AT Edwards and Dr Bill Grant.^{3,4} Their observations helped me to

understand the origins and the nature of the psychiatric profession in New South Wales. More recently I found that both autobiographies contained data that were relevant to the subject of this dissertation. I am grateful for their contributions and I hope that some future reader may find useful data in this memoir.

Origins and childhood

I am a fifth generation Australian. My forbears were Anglo-Celtic. My paternal great-great grandfather, Isaac White, was convicted of theft of materials from a house in Somerset, sentenced to death and transported from Plymouth to New South Wales, where he arrived in 1832. Fourteen years later, his wife, Annie, joined Isaac in NSW. Annie and Isaac built a hotel in Bega where Annie became a successful licensed publican. My father, William (Bill) White, worked as a clerk at the Sydney Water, Sewage and Drainage Board. He died of a heart condition before my seventh birthday. My maternal grandfather was a saddler who established a leather-goods factory in Alexandria, which is about eight kilometres to the south of Sydney Cove. His forebears came from Cornwall. My maternal grandmother had Irish blood and was a Roman Catholic, which ensured that I was raised in that faith. However, my parents were not devout. Like many middle-class Catholics in Sydney in the middle of the twentieth century, they voted for the Labor Party.

I had two siblings, a brother and a sister who were respectively older than me by eleven years and nine years. As a child and as an adolescent I had no direct contact with anyone who was identified as suffering from mental illness, but my mother told me that the builder of our house had later been admitted to Callan Park Mental Hospital in a state of severe depression. I was told nothing else about his fate.

None of my immediate family or their immediate friends completed more than nine years of formal schooling. Thanks to my mother I had a good education. I gained matriculation to the University of Sydney from the Christian Brothers College at Waverley. At the University of Sydney, I benefited from a Commonwealth Scholarship with an attached 'living allowance'. My mother supplemented that allowance during my years as an undergraduate. For twelve months, in 1958 I studied Law part-time at the University and as an articled law clerk but I then switched to the Faculty of Medicine. The decision to change Faculties suited my most deeply held interests and was probably the best decision that I ever made.

Undergraduate years in Medicine

In my first year as an undergraduate medical student, I took psychology as an elective unit. In 1962 I withdrew from my studies to undergo treatment of a subclinical episode of pulmonary tuberculosis which had been identified during a public health campaign which employed mass miniature radiography. I quickly responded to 'triple therapy' of streptomycin, para-amino salicylic acid and isoniazid during twelve weeks in the Cameron Wing of St Vincent's Hospital but did not return to my undergraduate studies until February of 1963. During my undergraduate years the clinical subject that most interested me was psychiatry. David Maddison was the sole Professor of Psychiatry. Maddison had nailed his colours to the masthead by choosing the strongly psychodynamic American textbook: Modern Clinical Psychiatry by AP Noyes and LC Kolb (6th Edition (1963) WB Saunders, Philadelphia), as the recommended text for undergraduate training in psychiatry.

Early years as a medical graduate (1966 to 1968)

During 1966, while an intern at St Vincent's Hospital, I completed a ten-week placement at the Caritas Psychiatric Centre, which had then been functioning for nearly two years. I was supervised by the Director of the Caritas Centre, Dr John Woodforde. A year later Woodforde published a brief but comprehensive account of the origins and early years of the Caritas Centre in the *Medical Journal of Australia*.⁵ Woodforde's account is totally consistent with my memories of the Caritas Centre. Woodforde was then a young man; a quietly spoken and thoughtful mentor, and a person who I admired. My experiences during those ten weeks at Caritas were stimulating and enjoyable and I wondered whether I should later train to become a psychiatrist. However, many of my fellow students and most young graduate medicos thought that psychiatry was a second-rate specialty, and I postponed any decision about specialisation until I had gained more medical experience.

In the early months of my internship at St Vincent's Hospital, I married Margaret McElligott, who was a qualified nurse. We found that my incredibly long working hours, and my nights on duty at the hospital, kept us apart and was difficult to tolerate. Therefore, at the start of 1967 I took a position as a medical officer in the highlands of New Guinea where Margaret and I could spend more time together while I worked as a doctor and she as a registered nurse. I then applied for a position as a ship's doctor so that we could travel to London. Our salaries in New Guinea provided enough capital to have a holiday in Europe before finding accommodation and work in London. In 1967 I had few professional ambitions beyond obtaining a post-graduate qualification that would allow me to obtain an appointment in an Australian hospital when we eventually returned to Sydney. In England, between 1968 and 1970 we shared the company and friendship of a group of young medical graduates from Sydney, several of whom worked in London at St Bernard's Hospital—formerly Hanwell Lunatic Asylum—and at Friern Hospital—formerly Colney Hatch Lunatic Asylum.

Senior House Officer and Registrar in Psychiatry in the UK (1968 to 1970)

In September 1968 my first appointment as a senior house officer was at the Netherne Psychiatric Hospital in Surrey. My reasons for seeking an appointment at a large mental hospital close to London resembled those of many young Australian doctors who worked in Britain in the late 1960s. London was rich in cultural treasures and ‘swinging’ before Sydney became at all cosmopolitan. On the debit side of the comfort ledger, the salaries of house officers were relatively meagre and the winters were harsh. However, if one chose to work in the British mental health service, one could find centrally-heated peppercorn rental accommodation within the grounds of mental hospitals. The junior staff echelons of the British mental hospitals contained many doctors from Commonwealth countries. Australian medical graduates were well regarded for our training and our qualifications, and we were easily able to gain appointments as house officers and registrars in mental hospitals. There were some opportunities for appointment in the academic departments of London’s major teaching hospitals, which included the Maudsley Hospital. However, those appointments were at the base of a competitive academic ladder and were sought after by ambitious British graduates who often had the advantage of several years of training in psychiatry. Between 1968 and 1970, I knew two Australian psychiatry trainees who were working in major general teaching hospitals, i.e. Guy’s Hospital and the Maudsley Hospital. Junior appointments were also possible at specialised psychotherapy facilities, such as the Tavistock Clinic and the Cassel Hospital, but those appointments were sought by trainees who had significant psychiatric registrar experience and who intended to subspecialise in psychotherapy.

Prior to 1971 when the Royal College of Psychiatrists came into existence, the only recognised specialist qualification in psychiatry in the UK was the Diploma of Psychological Medicine (DPM). In Australia, the Australian and New Zealand College of Psychiatrists had been created in 1964, and Membership of the ANZCP was about to become the standard qualification for registration as a consultant psychiatrist. However, a British Diploma of Psychological Medicine was still recognised as sufficient specialist qualification for appointment as a consultant psychiatrist in the health service of New South Wales. Therefore, my initial professional plan was to aim for a DPM, which might take two years, and to then decide whether I should return to Australia or to stay in the United Kingdom. During those two years, I was mainly focussed on my marriage, on gaining broad professional experience and on enjoying life in London. In those years I had no higher professional aspirations.

My sole supervisor at Netherne Hospital was its Medical Superintendent, Dr Rudolf Freudenberg. Freudenberg was a modest man who made no attempt to capitalise on his reputation or the great depth of his professional experience. He had left Germany in 1935, and then left Austria in 1936 to avoid National Socialism. In Vienna he had studied under Manfred Sakel, the inventor of insulin coma therapy. Freudenberg is sometimes credited with introducing insulin coma therapy into England, but that role may have been shared with others. As the years passed, Freudenberg's professional energies switched to social and community-oriented therapies. Many years later it struck me that Freudenberg's transition from an interest in biological treatments to community, social and administrative psychiatry resembled the one adopted by one of his predecessors as Medical Superintendent at Netherne Hospital, Dr Eric Cunningham Dax.

Netherne Hospital had opened in 1905 to accommodate about 960 patients. Within decades it held twice that number. Dax became the Deputy Medical Superintendent of Netherne Hospital in 1939 and its Medical Superintendent in 1941. In 1942 he introduced prefrontal lobotomy as a therapeutic option for some patients at Netherne. He then conducted research concerning the outcomes of lobotomy and of other physical treatments, including pyrotherapy. After the War, Dr Leslie Kiloh came to train and to work at Netherne. Kiloh and Dax developed a close working relationship and a friendship which continued after both migrated to Australia. In 1952 Dax went to Melbourne to head the newly created Mental Health Authority of Victoria. Leslie Kiloh migrated to Sydney in 1962 to accept the Foundation Chair of Psychiatry at the University of New South Wales. My brief time at Netherne Hospital made me aware of the close linkages between British and Australian psychiatry. Kiloh and Dax belonged to an impressive contingent of British psychiatrists who moved to Australia in the post-war decades to take up leadership appointments in universities and state psychiatric services.⁶

The introduction of biological treatments, which included electroconvulsive therapy (ECT), in the late 1930s and antipsychotic drugs in the mid-1950s had led to dramatic changes in the management of psychiatric disorders at Netherne Hospital. There was a much faster turnover of acutely ill patients during the early 1960s and attention turned towards the creation of psychiatric rehabilitation programs for chronically ill patients. Netherne developed a reputation for the high quality of its workshop and outdoor and rehabilitation programs. After Enoch Powell, as Minister for Health (1960-1963), announced the plan to close all the mental hospitals, Netherne developed community, social and art therapies, but was bound to shrink in size and importance. Netherne Hospital finally closed in 1994. When I commenced my duties in 1968, Netherne Hospital, was a somewhat isolated mental hospital complex on the

top of a pleasant, leafy plateau. From the vantage of a young trainee psychiatrist, Netherne was no longer a dynamic institution. It lacked a consistent in-service medical officer training program. The other disadvantage of Netherne was that travel to the centre of London was slow and difficult. I had responsibility for a total of more than 120 patients. I spent the mornings in an admission ward in a 'villa' away from the main institutional buildings and during the afternoons I visited the chronic and rehabilitation wards that were scattered in a semicircle behind the main entrance and administration block. Margaret and I had a cosy, centrally-heated two storey semi-detached cottage in the hospital grounds. This gave us the capacity to host our Australian friends who would sometimes visit from London at weekends.

However, being 25 kilometres from central London, psychiatric training and social opportunities were very limited. After our first winter at Netherne, I sought and obtained a registrar position in North London at Friern Mental Hospital.⁷ At Friern Mental Hospital, we had a centrally-heated apartment in a tower block at the eastern end of the main building, adjacent to an infamous corridor that has featured in several movies that depicted gothic horror or psychiatric madness, including 'Britannia Hospital'. That enormous building was E shaped. The smaller arms of the E projected southwards and contained most of the wards for chronic patients. Friern Hospital was emblematic of mental hospitals in the United Kingdom. It was reputed to be the most expensive mental hospital ever built.⁷ It was designed on the advice of John Conolly and was opened by the Prince Consort in 1851 as Colney Hatch Lunatic Asylum. There were several extensions to the original building and within a decade it housed more than two thousand patients. In 1937 it was renamed Friern Mental Hospital. As a young registrar, in 1969, I was far more concerned about my immediate clinical responsibilities than about Friern's historical importance.⁷ I was ignorant of the fact that Dr Norton Manning, the first Inspector-General of the Insane for New South Wales, had visited

Colney Hatch Asylum in 1867-68 as part of his historically important study-tour of the world's main lunatic asylums.⁸

Prior to my appointment at Friern, the acute admission wards had undergone major upgrading and several youthful consultant psychiatrists had been appointed. These innovations meant that, when I commenced at Friern early in 1969 the standard of care in the 'acute' wards was good but I found it harder to judge the quality of care in the 'chronic' wards, where there was an atmosphere of placid demoralisation. All new admissions from Hampstead and Islington came to a single-story 'villa' which had been constructed some decades earlier in front of the main hospital complex. At Friern I worked for three consultant psychiatrists, probably best described as eclectic in their psychiatric attitudes. There was a specially appointed psychodynamic consultant on the staff of the Friern Hospital, but his influence on the hospital's culture seemed limited. A more obvious presence was that of Dr Richard Hunter, who headed the team that admitted from the Harringay region of London. Richard Hunter was famous for his publications, which were co-authored by his mother, Dr Ida Macalpine, concerning the history of psychiatry. Their best-known works were *Three Hundred Years of Psychiatry, 1535 to 1860: A History Presented in Selected English Texts* (1963)⁹ and *'George III and the Mad-Business* (1969)¹⁰. Dr Hunter was also well known, and was sometimes criticised, for his fierce rejection of psychodynamic psychiatry and his enthusiasm for biological investigations. One of his research projects required the performance of lumbar punctures on many of his newly-admitted patients. At Friern Hospital there were 'grand rounds' meetings at regular intervals, and far more interaction with consultant psychiatrists and senior registrars than I had experienced at Netherne Hospital.

My main responsibilities at Friern Hospital lay in the 'acute' ward, or villa. Each day began with a meeting in the acute admission ward which brought together all the clinical staff and all the patients in the villa. This was followed by attendance to the new admissions followed by my briefer attendance to other patients on the acute ward. Later in the day I would visit, examine, talk with and treat patients in a small number of chronic wards. I became very conscious of a dichotomy between 'acute' wards and 'chronic' wards. Some of the latter wards were intended for intermediate-stay patients or for rehabilitation purposes but most seemed destined for long-term care. My responsibility for patients in the 'chronic' wards was less defined than in the admission wards. One of the senior registrars had been appointed to systematically assess and to manage patients in those non-acute wards. Unlike the 'acute' wards, the 'chronic' wards, which were in the vast asylum complex, did not mix the genders of the patients or the genders of the nursing staff. My main supervisor was Dr John Bradley, a relatively young man who had recently been appointed as the Medical Director of Friern Hospital. He was a strongly motivated therapist, a good supervisor and would, much later, become a valued friend. However, I do not recall much supervision of my work in the chronic wards, which were a cultural world apart from the acute admission wards. Each week, in the acute admission ward, I had a significant role in two or three 'ward rounds' at which I would recount the management of each of the patients. Each patient would then be escorted by a nurse to sit in front of all the relevant therapists: consultant psychiatrist, nurses, social workers, occupational therapists and occasional psychologists. The main interlocution would be between the consultant psychiatrist and the patient, but other staff would then be drawn into management discussions. When discharged, patients were mostly followed up by their general practitioners, but some were referred to psychiatric outpatient clinics at general hospitals near their homes.

While employed as a psychiatric registrar at Friern I had junior honorary appointments at the Royal Free, the Whittington and the Royal Northern Hospitals. The Royal Northern and the Whittington did not have psychiatric inpatient units or any attached salaried mental health staff. In the UK, in the late 1960s, the processes of devolving psychiatric services to the general hospitals from the stand-alone psychiatric hospitals was at the earliest stage of its evolution. I recall attending outpatient clinics at general hospitals and reviewing some patients who had recently been discharged from Friern Hospital. More often I assessed patients who had been admitted to the medical wards following attempts at suicide. My sources of supervision were remote; I therefore mostly relied on my own clinical judgment. When I performed psychiatric OPD services I had very few interactions with mental health services which were based in the community. However, Friern Hospital and the general hospitals provided some community services; these were performed by mental welfare officers or social workers.

During those years in the UK, I received limited formal or structured training in psychiatry. I attended a few lectures in psychiatry outside my mental hospital base at Friern Hospital. I relied mainly on supervision and advice from Dr Bradley, and from discussions with other psychiatric trainees and from discussions at grand rounds. Therefore, most of my study program depended on my own initiative. I had a large clinical load and saw many and varied patients, which ensured that I gained valuable clinical experience. I attended one weekend crash course in psychiatry at New College, Oxford, to prepare myself for the DPM examination. I had absolutely no contact with private psychiatric hospitals or psychiatrists in private practice.

Adjacent to Friern Hospital was Halliwick Hospital, a ‘voluntary admission’ government-funded psychotherapy facility which contained 145 beds. I was told that Halliwick had been built in 1958 with the intention that it would provide acute admission accommodation facilities for Friern Hospital but, for reasons which I never understood, Halliwick was converted into an independent hospital for the treatment of patients who had psychoneuroses and selected personality disorders. The interaction between Friern and Halliwick hospitals was minimal. I recall only one day during my two years in London when the staff of the two hospitals met for clinical presentations and formal in-service training. I learned much later that the limited relationship between Friern and Halliwick hospitals resembled, in some ways, that which had existed between Callan Park and Broughton Hall hospitals in Sydney before the 1970s.

Consultant Psychiatrist in New South Wales (1970-1975): The Psychiatric Research Unit at Rozelle and the Callan Park/Rozelle Hospital

Towards the end of the English summer of 1970, having acquired a DPM, I returned, with Margaret and our infant son, to New South Wales. Before departure, I had contracted to join the mental health service of NSW as a consultant psychiatrist. In 1970, Dr Bill Barclay was the Director of the State psychiatric services. The NSW State Government seemed to be doing whatever it could to encourage the recruitment of medical graduates and young consultant psychiatrists into its mental health service. Medical staff employed in the service could obtain cheap and comfortable accommodation in the spacious grounds of the mental hospitals. Some of these advantages were a legacy of the asylum era when medical staff were required to remain on call outside normal working hours so that they could attend to emergencies which might occur at any hour of the day or night. The superannuation arrangements for staff in the mental health system was far more generous than that available

elsewhere. In the early 1970s, medical staff who were employed in the mental health service of NSW belonged to more assertive trade unions than those that managed staff of the general hospitals. By the 1970s, public attitudes towards psychiatry and psychiatrists were steadily improving. For all these reasons the prospect of a career as a consultant psychiatrist in the mental health service of NSW had become an attractive option for many young doctors. My brief time as a consultant psychiatrist at Newcastle Psychiatric Centre at Watt Street rewarded me with knowledge about the practice of psychiatry in New South Wales and it allowed me time to reacclimatise. However, Margaret and I were keen to return to Sydney, and I now became interested in professional advancement. Four months after our arrival in Newcastle, I applied for and gained a very interesting and prestigious appointment as the Acting Psychiatrist-in-Charge of the Psychiatric Research Unit (PRU) at Rozelle Hospital. I found myself in a challenging role as a clinician and as the administrator of an unusual research facility. The history of the Psychiatric Research Unit (PRU) can be gleaned by the reading several papers, one of which I co-authored, and in a book that was recently published by my predecessor at the PRU, Dr David S. Bell.¹¹⁻¹³

The PRU, formerly known as the Cerebral Surgery and Research Unit, (CSRU), had opened in 1958 with Dr Harry Bailey, the Medical Superintendent of Callan Park Hospital, as its Director.¹² Bailey left the NSW mental health service in 1961 shortly after the McClemens Royal Commission. In 1964 Professor Leslie Kiloh was appointed the Acting Director of the CSRU and its name was changed to the Psychiatric Research Unit (PRU). However, the day-to-day administrator of the PRU between 1963 and 1970 was Dr David Bell. Dr Bell claimed, in his book *‘Welcome to the Looney Bin’*, that he shared the leadership of the research programs at the PRU with Professor Kiloh.¹³ It was Dr Bell’s role at the PRU that I now inherited. However, I was very inexperienced and I therefore welcomed the guidance of

Professor Kiloh, who visited the PRU for at least one half day each week from his main academic and clinical base at the Prince Henry Hospital. Kiloh was an excellent administrator, teacher and supervisor. In 1966 Kiloh had initiated a program of amygdaloid psychosurgery for aggressive behaviour.¹² The surgical intervention component of that program had run until 1968, when the stereotactic frame that was essential for the operative procedure was accidentally broken. With the program in suspension, I conducted research on the outcomes of that program on the eighteen subjects who had already been treated by amygdaloidotomy.¹⁴

During my time at the PRU, I learned a lot about clinical psychiatry, administrative psychiatry and psychiatric research. However, I became increasingly uncomfortable about the ethical underpinnings of the psychosurgery program, for which my appointment gave me some administrative responsibility.¹⁵ Therefore, after about eighteen months, and before the operative procedures resumed, I sought a transfer from the PRU to Ward 12/13 of Callan Park, which was the acute admission ward for the Eastern Suburbs of Sydney. A lesser but significant factor in my decision to move to Ward 12/13 was my desire for supervision in psychodynamic psychotherapy by Dr Max Chapman, who was the Director of Ward 12/13. For more than a year, I was responsible for patients from part of the Eastern Suburbs. Once a week I attended a newly established community clinic near Bondi Junction and an outpatient clinic at the Waverley War Memorial Hospital.

In 1973 Dr Andrew Bennett, the Superintendent of Callan Park/Rozelle Hospital, asked if I would accept directorship of Ward 2 of Broughton Hall Hospital. All the wards of Broughton Hall Special Hospital had, until recently, only accepted voluntary admissions but it was, in

1973, in the process of amalgamation with Callan Park Hospital to become the fully gazetted Rozelle Psychiatric Hospital. One of my responsibilities was to ensure that as many of the long-term clientele of Ward 2 as possible should be rehabilitated and discharged from inpatient care. This would allow the involuntary admission and treatment of seriously mentally ill patients to Ward 2. My undergraduate teaching responsibilities increased and I was appointed as a Clinical Supervisor in the Department of Psychiatry at the University of Sydney. I was free to work elsewhere on Saturday mornings and did so at the Northside Clinic, a private clinic at Greenwich that was led by Dr John Ellard. This gave me valuable experience in the private practice of psychiatry and some additional income.

Consultation-Liaison Psychiatry: Staff Specialist Psychiatrist at Sydney Hospital (1975-1981)

In 1975 a position as a staff specialist psychiatrist at Sydney Hospital was created and advertised. I sought and gained that appointment. Prior to that year, the only mental health professionals at Sydney Hospital were four or five honorary psychiatrists and a clinical psychologist who attended the OPD clinics and Dr Warren Argall, a Lecturer at the University of Sydney who had taken over a liaison attachment to the Melanoma Clinic which had been established some years earlier by Dr Maurice Sainsbury (See *Chapter Twelve: The genesis of consultation psychiatry and liaison psychiatry in New South Wales*). Shortly after my appointment at Sydney Hospital, Dr Argall resigned from Sydney Hospital and from the University of Sydney to establish a private psychiatric practice.

Sydney Hospital was a very old but respected teaching hospital of the University of Sydney. It was situated at the top of Martin Place in Macquarie Street. It had between 200 and 300

medical and surgical beds, but none allocated to psychiatry. I regarded the absence of a psychiatric inpatient service as an opportunity to train and to establish myself in the new and exciting sub-specialty of consultation-liaison psychiatry. The birth of consultation-liaison psychiatry in New South Wales was described in *Chapter Twelve* of this dissertation. Prior to my appointment there were only two consultation-liaison staff specialist psychiatrists in the adult general hospitals of New South Wales. Dr Noel Wilton had been at the Prince of Wales Hospital since 1973; Dr Richard Perkins at Prince Henry Hospital since 1974 or early 1975.

I relished the prospect of working in a major general teaching hospital. For me, the greatest disadvantage of resignation from the NSW State psychiatric service was that I would lose access to the generous public service superannuation system. However, there were more important considerations. Between 1975 and 1978 I was very busy and happy in my clinical role as the only full-time staff specialist psychiatrist at Sydney Hospital. I provided psychiatric consultation to all its medical and surgical departments. In my new role I gave particular attention to the Emergency Department, which I visited at the commencement of each working day. I quickly established a liaison attachment to the Neurology Department, which was directed by Professor Jim Macleod, who I knew from his previous sessional attendances at the Psychiatric Research Unit. Thereafter I attended the weekly meetings of the medical, nursing and paramedical staff of the neurological and neurosurgical service who assembled to discuss the management of all the inpatients. However, most of my professional time was spent in the other wards of Sydney Hospital, including several hours each morning in the Emergency Department. I was offered an appointment as a Clinical Lecturer at the University of Sydney and I supervised undergraduate medical students who began to come to Sydney Hospital to gain experience in consultation-liaison psychiatry. I also sometimes

supervised trainee psychiatrists who came to gain experience in C-LP at Sydney Hospital from the Gladesville Psychiatric Hospital.

Testing the waters in private practice (1978-1981)

In 1978 I elected to reduce my commitment as a salaried staff specialist from full-time to half-time and to test whether I was suited to a career in private practice. I took rooms at Hengrove Hall in Macquarie Street and at the Hale Clinic in Mosman and obtained a VMO appointment at RPA Hospital and an honorary appointment as a consultant psychiatrist at St Luke's Private Hospital. I admitted and managed patients in the Allanbrook Private Hospital in Mosman. My testing of private practice lasted for three years. I gained valuable experience but steadily came to the realisation that I was better suited to the role of a salaried staff psychiatrist in a general teaching hospital than the role of a private practitioner. In 1981, when Dr Greg Steele resigned from his full-time appointment as a staff psychiatrist in consultation-liaison psychiatry at RPA Hospital, I applied for that position. I believed that, in the large academic Department of Psychiatry at RPA Hospital I would learn more and be able to improve my clinical and research skills.

Staff Specialist Psychiatrist at RPA Hospital

For thirty-two years between 1981 and 2013 I held an appointment as a staff specialist psychiatrist at RPA Hospital. At various times I also exercised administrative roles within the Department of Psychiatry, including head of its consultation-liaison service, Acting Director and Director of the Department. I enjoyed the supervisory and teaching responsibilities associated with my Clinical Senior Lectureship at the University of Sydney. During those years, for reasons that are discussed in *Chapter Twelve*, consultation-liaison psychiatry

flourished throughout Australia. The consultation-liaison service at RPAH was the best staffed C-L service in New South Wales. It enjoyed the good fortunes associated with the new sub-specialty and I shared in those rewards. However, I also maintained an interest in psychotherapy and, for several years, wondered whether I should spend more of my time studying and performing intensive psychotherapy. Early in the 1980s I took on several patients in intensive psychotherapy and sought supervision in psychodynamic psychotherapy with a well-known supervisor. During the 1980s, I had more than a hundred hours of personal psychotherapy. I did so for personal reasons but also because, in psychotherapy circles, it was held that the experience of being a patient in psychotherapy was essential for anyone who aspired to become a psychotherapist. For many years I was a Member of the Australia and New Zealand Association of Psychotherapy. For several years I was the coordinator of the psychotherapy strand in the program for the training of psychiatrists at the Institute of Psychiatry. In 1994, I became a founding member, and committee member of the NSW State branch of the newly created Section of Psychotherapy of the RANZCP. In the late 1990s I became involved in the promotion and teaching of Interpersonal Psychotherapy (IPT), which, in my opinion, is not radically different to supportive psychotherapy. For about five years I was a member of the Society for Psychotherapy Research (UK). I maintained a deep interest in psychotherapy for the rest of my career, but my main identification remained with general hospital consultation-liaison psychiatry.

There were many opportunities to visit the UK or the USA on study leave. When I visited the UK in 1983, I was able to discuss clinical, administrative and political issues with several liaison psychiatrists. I learned that liaison services in the UK were limited to a small handful of academic departments of psychiatry and were struggling to gain traction. Six years later, a survey of liaison psychiatric services in the United Kingdom and Eire would confirm my

earlier observations.¹⁶ In 1983, I thought that we who were engaged in C-LP in New South Wales were fortunate to have the strong support of the Mental Health Branch of the New South Wales Department of Health and of the RANZCP.

Early thoughts about a med-psych ward at RPAH

In the 1980s there was a global wave of interest in the possibility of creating wards in tertiary level general hospitals that could simultaneously provide a very high standard of medical care and psychiatric care to patients who suffered, simultaneously, from serious psychiatric disorders and medical illnesses. In the mid-1980s there were only a few well-established med-psych wards in existence and most of them were in the USA. Conventional psychiatric wards in general hospitals can usually manage patients who have minor medical conditions, but conventional psychiatric wards cannot manage patients who are seriously medically ill, who are bedbound or who require close medical and nursing monitoring. Some leading psychiatrists proposed that med-psych wards might be able to provide a clinical environment where it would be possible to manage patients who were too medically ill to be managed in a standard psychiatric ward and too psychiatrically ill to be managed in a medical ward.^{17,18}

In December 1985 I took study leave during which I visited a prominent liaison psychiatrist, Dr Jim Strain, at Mt Sinai Hospital in New York. I intended to learn about his consultation-liaison service and about the medical-psychiatry inpatient unit which had been established a few years earlier at Mt Sinai Hospital.¹⁹ Unfortunately, that med-psych unit closed before I reached New York. Dr Strain told me that the med-psych unit had, mainly for financial reasons, been converted into a geropsychiatry ward, but I suspect that the reasons for the failure of that med-psych ward were multiple and complex. From that experience I learned

that the fortunes of med-psych wards were uncertain. However, for nearly a decade after that study leave in 1985, I believed that, in a taxpayer-funded tertiary level public hospital in NSW, such as RPA Hospital, it might be possible to create and to maintain a clinically very useful med-psych ward. I therefore put some energy towards the creation of a med-psych ward at RPAH. In May 1990, at the American Psychiatric Association Annual Meeting in New York, I updated my knowledge about med-psych wards by attending a Continuing Medical Education Course titled 'Developing and Operating a Med-Psych Unit' that was directed by Dr Barry S Fogel.²⁰ I also made plans for study leave a few years later to visit med-psych units in Buffalo, NY, and at Stanford in California. During those visits my American hosts repeated the advice I had obtained during earlier visits to the USA that small or innovative psychiatric services were automatically vulnerable in the USA if financial or other pressures should eventuate and might quickly disappear.

The creation of Area Health Services and the 'mainstreaming' and 'integration' of mental health services at RPA Hospital

Following the passage of the NSW Health Services Act of 1986, twenty-three Area Health Services were established as statutory bodies in New South Wales. In 1988, by a proclamation in the New South Wales Government Gazette, the number of Area Health Services was reduced to ten. The intention of the NSW Government was to establish health services which focussed on geographically defined communities. One of these Area Health Services was the Central Sydney Area Health Service (CSAHS). All the general hospitals in the local government areas encompassed by CSAHS, including RPA Hospital, Balmain Hospital and Canterbury Hospital came under the direct control of the Area Board of CSAHS. In 1993 the Concord Repatriation Hospital was transferred from the Federal

Government to the NSW State Government and came under the administration of the Area Board of CSAHS.

In 1991 the NSW State Government published its policy of ‘mainstreaming’ and of ‘integration’ of the NSW psychiatric services.²¹ In the same year, the Central Sydney Area Health Service issued its own Strategic Plan for Central Sydney.²² The psychiatrists who worked at RPAH then had every reason to believe that the Psychiatry Department at RPAH was about to become part of a service which would primarily be focused on the mental health needs of a clearly delineated geographic community. If that happened, some of the beds in the inpatient service at RPAH would probably be gazetted to manage patients who would be held under the provisions of the Mental Health Act (1990). A question remained in some minds—including my own—whether RPAH might retain some ‘voluntary’ psychiatric beds for purposes which were related to the tertiary medical functions of RPA Hospital. As Acting Director, and later as Director of the Department of Psychiatry I was frank about the fact that I wished for that to happen and that I hoped that some of those ‘voluntary’ beds would eventually constitute a med-psych unit. I realized that, according to the definition proposed by Richman and Harris²³ those med-psych beds would provide a function which was more ‘adjunctive’ than ‘pivotal’ within the psychiatric service of CSAHS, and I anticipated that my plan for a med-psych unit at RPAH might meet strong opposition.

I intended to argue that most of the inpatient psychiatric service should remain ungazetted and that a number of beds—perhaps fifteen—should be converted into a medically sophisticated med-psych unit. I would argue that the main gazetted psychiatric units for the

‘integrated’ psychiatric functions of CSAHS should be at Canterbury Hospital, Balmain Hospital or at Concord Hospital.

Conversion of the Department of Psychiatry at RPA Hospital into an ‘integrated’ community-oriented psychiatric service (1990-1996)

In the late 1980s, Professor Beaumont had relinquished much of his claim to leadership of the Department of Psychiatry at RPA Hospital by formally recognizing Dr Herb Smartt as the Administrative Director of Psychiatry at RPAH. However, Beaumont retained a significant role at RPAH as the Academic Director of the Department. It is my personal belief that a major consequence of Beaumont’s withdrawal from leadership of the RPAH Psychiatry Department was that there would be little or no effective opposition by the University of Sydney to the proposed transformation of the Department and the eradication of the thirty ‘voluntary’ psychiatric beds at RPAH. It seems that the real power of the University to influence events was already limited by the fact that nearly all the financial support for the Department of Psychiatry at RPAH came from the NSW Department of Health, and very little from the University. In 1990, following the elevation of Dr Smartt to a new position of Area Director of Psychiatry for the Central Sydney Area Health Service (CSAHS), the Chief Executive of CSAHS, Dr Chris Scarf, invited me to fill the gap created by Dr Smartt’s departure from his position of the Administrative Director of the Psychiatry Department at RPAH. Professor Beaumont and Dr Smartt both encouraged me to accept that appointment, but I had mixed feelings about doing so. I had been content with my role as a clinician and with headship of the consultation-liaison service. I hesitated to accept the appointment for several reasons. Whereas I agreed with the principles of ‘mainstreaming’ and of ‘integration’ of the psychiatric services of New South Wales, and of CSAHS, I believed that it was very desirable that a workable number of ‘voluntary’ psychiatric beds should be retained at RPAH.

I realised that this would be a financially costly project for the State Government, and that the idea would meet strong opposition, but I thought that the retention of non-gazetted beds would provide many benefits for psychiatric and medical patients at RPAH. The second reason why I hesitated to accept the role of Director was that I had lived through years at the Rozelle Hospital when psychiatric beds had been abolished before adequately staffed community services had been established and I feared a repetition of that story while I bore responsibility for matters over which I had little control. Thirdly, my clinical interest, for more than fifteen years, had been centered on consultation-liaison psychiatry and not on inpatient psychiatric services or on community psychiatry. On the other hand, if I accepted some administrative power, I might be able to help to defend the best features of the Department of Psychiatry at RPAH. These were the excellence of its inpatient service and of its consultation-liaison service. With the cooperation of my medical and nursing colleagues—especially Dr Kristin Kerr, in charge of the inpatient service, Dr Robert Gribble, for the consultation-liaison service and Mr. John Wu, the Nurse Unit Manager for the inpatient service—I might be able to save some ‘voluntary’ beds and create a medical-psychiatry inpatient unit within the rebuilt facility. I therefore decided to accept Dr Scarf’s proposal on the condition that he should create an additional staff specialist position in the consultation-liaison service to compensate for the loss of my hours in a clinical role. I proceeded to administer the Department as Acting Director, and then as Director, between 1990 and 1996 and to continue to work as a consultant psychiatrist on the consultation-liaison team. It became possible to sequester a little time for clinical research on medical patients who were disliked by health professionals. My Directorship was eventually formally confirmed on 10th August 1995 by Dr Diana Horvath, who had replaced Dr Scarf in 1992.

Following the publication, in 1992, of the *Strategic Plan for Mental Health for the Central Sydney Area Health Service*, Dr Herb Smartt, who had become the Area Director of Psychiatry, asked me to prepare a strategic plan for the Department of Psychiatry at RPAH which would need to be consistent with the over-arching CSAHS Mental Health Strategic Plan. I therefore convened a small working group which consisted of the Director of the Inpatient Unit, Dr Kristin Kerr; the incoming Head of the Consultation-Liaison Unit, Dr Robert Gribble; a Visiting Medical Officer in the Psychotherapy Unit, Dr Ray Cooper and myself. On 16th September 1991 I presented our completed '*Strategic Plan for the Psychiatry Department at RPA Hospital*' to the Head of the Division of Medicine at RPAH, Professor John Turtle and to the Area Director of Psychiatry, Dr Herb Smartt.²² In our *RPAH Strategic Plan* our committee proposed that only two or three of our thirty psychiatric beds should be gazetted. The availability of three gazetted beds would make it possible for us to admit and to detain persons under the provisions of the Mental Health Act when those persons had medical illnesses which required inpatient medical assessment and treatment. As for the creation of an 'integrated' community-oriented psychiatric service, we suggested that other general hospitals in CSAHS—Canterbury Hospital, Balmain Hospital or Concord Hospital—might be better suited than RPAH to maintain totally gazetted wards with mandatory responsibility for psychiatric services to nearby communities. We noted, in our *RPAH Strategic Plan*, that Concord Hospital and the Canterbury Hospital were also being considered by CSAHS as possible sites for fully gazetted and appropriately secure psychiatric admission wards. We argued, in our *RPAH Strategic Plan*, that, aside from the three gazetted beds, all the other beds at RPAH should retain their voluntary status. We proposed that those voluntary beds should be used to manage medically ill patients who had significant mental disorders and to treat psychiatric patients from nearby local government areas who did not need to be detained under provisions of the Mental Health Act. Some of those voluntary beds—between two and

four—would be sequestered for the management of mothers with their babies. Four or five voluntary beds would be sequestered for patients who had eating disorders. In support of these proposals, our committee argued that, because RPAH was a major ‘tertiary’ medical and surgical referral hospital, it was vital that we maintain an inpatient psychiatric facility which could manage patients who, in addition to a psychiatric disorder, had complex medical conditions. We envisaged that a well-qualified physician—an internist—would have a significant role as the regular consultant internist for our inpatient service. We also envisaged that the nursing staff employed in our revamped inpatient service would have advanced training in the management of medically ill inpatients. We were, in effect, proposing that a significant proportion of our inpatient beds would constitute a Type III or Type IV med-psych unit as defined by Kathol and others.¹⁸ Dr Smartt was not pleased with our proposal that there would only be two or three gazetted beds in our *Strategic Plan for Psychiatry at RPA Hospital*. He proposed a significantly modified plan whereby we would retain fifteen ‘voluntary’ beds and accept fifteen gazetted beds—the latter maintaining strict links with a geographic community. We saw little chance that our first proposals would gain the approval of the NSW Department of Health without Dr Smartt’s support and revised our proposal. A modified *Plan* proposing fifteen gazetted beds with tight community links was duly dispatched to the RPAH Hospital Management Committee and to the Division of Medicine of RPAH. It met with their approval and endorsement. Therefore, it seemed that the Psychiatry Department at RPAH might succeed in establishing an ‘integrated’ service with fifteen gazetted and therefore involuntary beds but retain fifteen ‘voluntary’ psychiatric beds, some of which might be used to create a medical-psychiatry unit. However, this was not to be.

In October 1992 the Director General of the Mental Health Branch of the Department of Health, Dr Noel Wilton, wrote to the Acting Chief Executive Officer of CSAHS informing

that partial gazettal of the beds would be contrary to the spirit of the Mental Health Act and was not an acceptable option. A copy of Dr Wilton's letter is appended as Appendix Four.

Wilton wrote that gazetted beds could still be used for 'voluntary' purposes:

There is known to be a misconception that gazettal of a whole unit in some way affects the patient mix or requires that numbers of involuntary patients greater than the unit can cope with must be admitted. That is no more than an urban myth. Admissions to all units are dictated by local operational policies. Such policies should and usually do describe what it is a unit will do and what is to be done with overflow patients of various types.²⁴

Of course, Dr Wilton was correct in stating that 'local operational policies' would determine how the beds in the inpatient facility would be employed. However, within any community-integrated psychiatric service, the management of the most severely mentally disturbed patients must always be given the highest priority. If all the beds in the ward were gazetted there was little chance that any of them would ever be available for other purposes. This made it highly likely that the new inpatient psychiatric facility would only ever provide beds for patients who were severely mentally ill. There would be little or no room for patients who were not suicidal or who did not exhibit behaviour that required careful monitoring and some security measures. Within a month of the receipt of Dr Wilton's letter, a detailed plan for a new inpatient unit of forty beds was approved and circulated to all the relevant stakeholders by the Mental Health Directorate of CSAHS. Ten of the forty beds in the rebuilt Missenden Unit would constitute an Acute Observation Area—a high security inpatient area where the most severely behaviorally disturbed, suicidal or uncooperative patients could be managed. The remaining thirty beds would constitute a secure psychiatric admission ward. Passage through the main entrance to the inpatient ward—for patients, for their families and for visitors—would be at the discretion of the senior nursing staff; the entrance would be locked

when passage was not occurring. The new inpatient service at RPAH would be ‘integrated’ in the sense that it would be responsible for servicing the adult mental health needs of three local government areas and sub-areas: Marrickville, Leichhardt and Redfern/Newtown. Only four or five of the forty beds were sequestered for the admission of patients who had eating disorders. Those patients could be admitted from local government areas other than those which were geographically linked to RPAH.

On 15th January 1993 all the beds in the inpatient service (now renamed the Missenden Unit) were gazetted by the NSW State Government. Between 1993 and 1996, while the psychiatric inpatient unit at RPAH was being rebuilt, the staff and patients of the inpatient service, led by my colleague, Dr Kristin Kerr, and the Nurse Unit Manager Mr John Wu, occupied temporary facilities at the Rozelle Psychiatric Hospital. Some additional details concerning the transformation of the psychiatric inpatient service at RPAH into an ‘integrated’ service are provided in *Chapter Ten: a renaissance in psychiatry in NSW (1961 to 1994)*. While the physical facility at RPAH was being rebuilt, the staff of the RPAH inpatient service undertook additional training in the management of involuntary patients at Rozelle Hospital and established tighter links with community services. During those three years I remained on site at RPAH where my clinical duties as a consultation-liaison psychiatrist were centered. When the Missenden Inpatient Unit reopened at RPAH in mid-1996, it did so as a fully gazetted admission centre with responsibility for the mental health needs of all adults under the age of 65 who resided in three well-delineated nearby local communities. That service, under the leadership of Dr Kerr, functioned exactly as required by the CSAHS Mental Health Directorate and by the NSW Department of Health. The consultation-liaison service was intact and functioned under the leadership of Dr Gribble. In July 1996 I formally requested to be relieved of the administrative responsibilities of Director of Psychiatry at RPAH. My

request was graciously received and granted by Clinical Professor Marie Bashir, who had, a few years earlier, succeeded Dr Smartt as the Area Director of Mental Health for CSAHS.

In 1997 I accepted Chairmanship of the Mental Health Division of the Medical Staff Council of CSAHS; that role did not require the execution of many administrative responsibilities or much of my time. During the next sixteen years I became increasingly involved in projects outside my clinical role as a consultation-liaison psychiatrist at RPAH. These included activities in the RANZCP—especially within its Section for the History, Philosophy and Ethics of Psychiatry. For nearly two years between 2009 and 2011 I performed duties as an elected Binational General Councilor of the RANZCP. In September 2013 I resigned from RPA Hospital. After that year I performed several assignments as a locum psychiatrist in regional areas of New South Wales. I relinquished my medical registration in 2017.

Conclusions

This professional memoir describes my experiences and my observations between the late 1950s when I was a medical student at the University of Sydney and 2017 when I relinquished my medical registration. The memoir includes data which support the contention which I stated in the Introduction to this dissertation concerning the influence of ideas about mental health services on the psychiatric services of New South Wales from the United Kingdom and from the United States. In 1970, when I returned from the United Kingdom to New South Wales after two years of psychiatric training and experience, I noted many similarities and some significant differences between the psychiatric services in the UK and those in Australia. For example, the private practice of psychiatry was an important component of the psychiatric services of New South Wales but was of much less relevance in

the United Kingdom. I noted the influence of senior British psychiatrists who had migrated, prior to the 1970s, to accept leadership roles in New South Wales and elsewhere in Australia. During the 1970s I observed that ideas from the United States concerning biopsychosocial approaches to mental illness, consultation-liaison psychiatry and community psychiatry were exciting great interest in New South Wales. In the early 1970s consultation-liaison psychiatry and community psychiatry saw rapid growth in Sydney. During that decade, developments in preventive and community psychiatry in New South Wales were at least on a par with, and might have been ahead of, those in the United Kingdom. In the early 1970s, ideas which had emanated from Rochester, NY concerning biopsychosocial approaches to psychiatry and general medicine, and about consultation-liaison psychiatry, were being successfully implemented in New South Wales and in other States of Australia. Likewise, ideas that emanated from the school of Gerald Caplan, in New York, were influencing the development of community psychiatric services in NSW. The differences that existed between developments in psychiatric services in the UK and in NSW struck me most forcefully in 1975 when I became a liaison psychiatrist at Sydney Hospital. The equivalent of my appointment as a liaison psychiatrist in New South Wales did not then exist in district general hospitals in Britain. Similar appointments were only possible in a small number of academic departments of psychiatry in a few major British cities. During the 1990s and the 2000s I was able, on many occasions, to attend annual conferences of the psychiatric profession in the UK, the US, Canada and various European countries. During study leave in those countries I gained the strong impression that members of the psychiatric profession within Australia were learning at least as much about developments in psychiatric services by local innovation and experiment as by the importation of ideas and observations from other countries.

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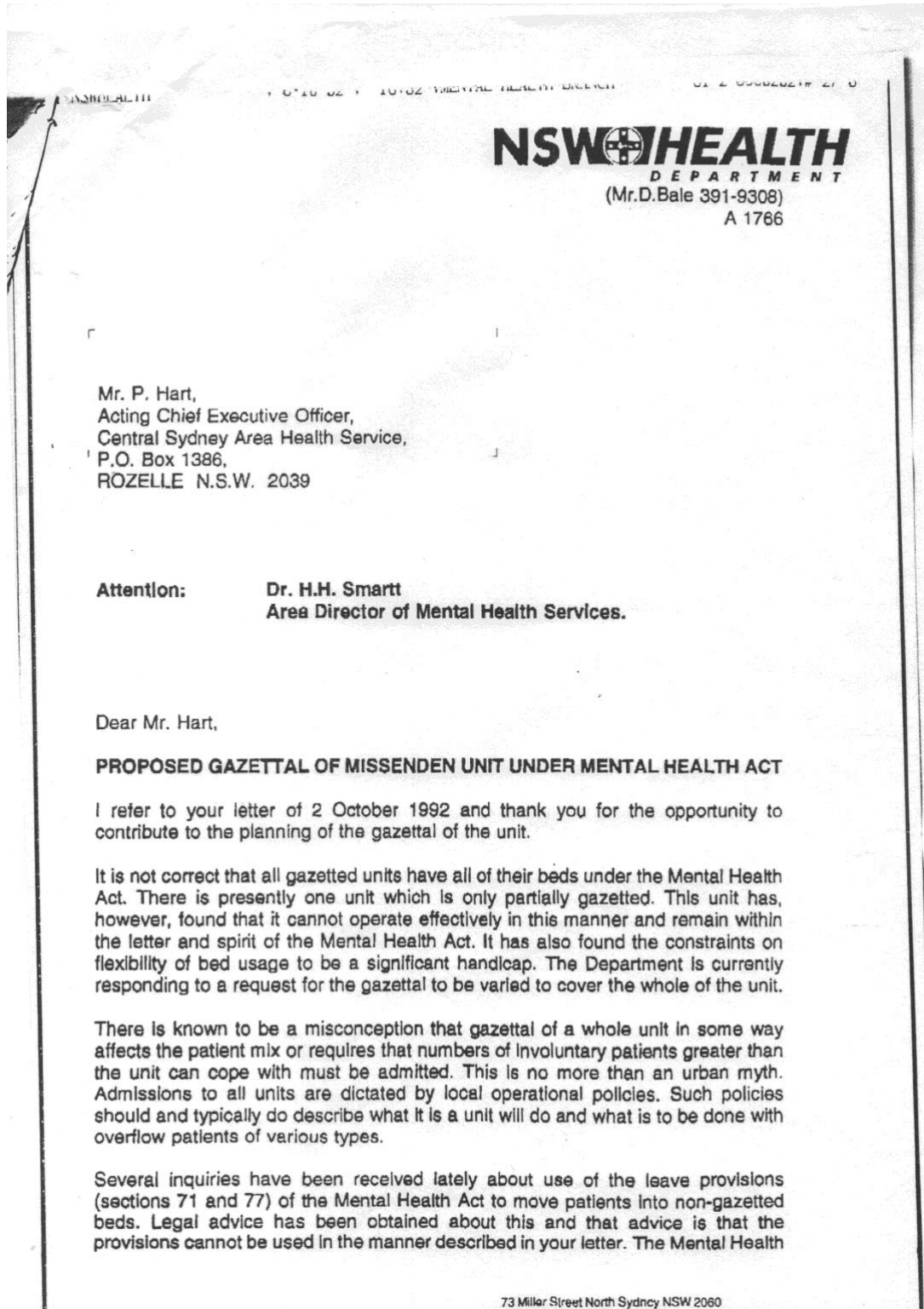
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Appendix Four

Letter from Director of Mental Health Services, New South Wales, re Partial Gazettal of the Psychiatry Ward at RPAH



Act provides unique powers to deprive citizens of their liberty and describes precisely where that deprivation will take place. It cannot take place in some other unapproved nearby place for the convenience of service provision. The leave powers in the Act are there so that patients can be excused from the environment where they are detained to receive other clinical care not available in that place or simply, once they are ready, be trialled on day leave, weekend leave etc.

I believe the Department would be very reluctant to agree to the part gazettal of any general hospital psychiatric unit; the Mental Health Branch would certainly not recommend such a proposal.

Yours faithfully,



Noel Wilton
for Director-General.
6 October 1992