

Report and Reflection on the Symposium at Hobart: “Laying the Ghosts of the Asylum Era: Anger Resolution in Psychiatry”

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Introduction and Background

At the recent congress of RANZCP at Hobart, I organized a 90 minute symposium with the title: “Laying the Ghosts of the Asylum Era: Anger Resolution in Psychiatry”. This symposium was a significant step in a protracted historical process, which still has a long way to run. The fact that this symposium was allowed to occur was itself significant, and I pay tribute to the college for this. To take the process further forwards I believe that a full report on the symposium is needed. This report provides historical context for the symposium, describes the historic shift now under way in psychiatry (as I see it), and some recent events leading up to the symposium. In describing the symposium itself I record contributions of the participants, and the subsequent discussion (including emotions of participants on the day). Since some of the shortcomings of the care offered in the asylums is related to clear misuse of available therapies, I include some detail, to explain how such misuse could have occurred. I conclude with a discussion of how all involved, whether mental health professionals, former asylum inmates, or their family members can come to terms with this history, as we all emerge from the asylum era.

The Historical Background: Why Anger?

Over the centuries, different societies have adopted a variety of approaches to the realities of mentally illness. The first mental hospitals appeared in the Islamic world, a culture noted for its benevolence towards disadvantaged and disabled persons. Later, in the Western/European world, the approach oscillated between times when enlightened attempts to institute humane care prevailed, and other times when less helpful attitudes, ranging from neglect to outright barbarism have been dominant. Psychiatry as a medical discipline, with a scientific agenda to fulfil, emerged in France after the revolution of 1789, under the leadership of pioneers such as Philippe Pinel and Étienne Esquirol. The “asylum era” in the English-speaking world developed from the early nineteenth century, with an Act of the British parliament in 1808 (not properly implemented), and a later one in 1845 which led to the building of large asylums in all regions of the country. Initially the concept of “asylum” was a worthy one, an attempt to do better than hidden back attics, or the private madhouses, and institutions such as “Bedlam” of the previous century. However, in the decades after the asylums were built, they became overcrowded, sordid, and often brutal and brutalising; and as their reputation spread they were generally feared by the public.

With these developments there have been many reactions from concerned people, hoping to regain more enlightened attitudes. Sometimes this has come from within the medical profession: The reformer Pinel was a medical man. In the Germanic world, the pioneer of neurology Wilhelm Griesinger, in 1868 published a controversial, and eventually influential book, calling for reform of institutional care. He advocated that mentally ill people should only be hospitalised for short periods, and otherwise should be integrated into their communities. Sometimes pressure for reform came from lay people. In 1796 a pioneering institution in Britain was opened in York - the York Retreat – founded by William Tuke, not himself medically trained, a member of the Society of Friends

(Quakers). By the nineteenth century this grew into the “moral treatment” approach, based on humane principles, supported by religious concepts, and early notions of psychology. Sometimes reformers have been people who were former inmates of the mental institutions, dissenting from the principles and practice of psychiatry of the day. In Britain these included the *Alleged Lunatics Friends Society* (founded 1845)¹ and the *National Society for Lunacy Law Reform* (founded in 1920). The latter advocated for major changes, and was a likely influence on the framing of 1930 Mental Treatment Act². This Act removed the stigmatising words “lunatic”, “pauper” and “asylum” from the statutes, and for the first time made provision for voluntary treatment in mental hospitals, and for temporary treatment without a person being certified. In New Zealand, there was also awareness as early as the 1870s of the malign environment create in mental institutions (mentioned in the documentary film “Mental Notes”, described below). In 1946 the very first hospital chaplain in the country, Rev Ian B Wilson, whose first posting was to Seacliff mental hospital, north of Dunedin, was so shocked by the conditions he saw there that he brought the matter before the Presbytery in Dunedin, and later organised collections on the streets of the city to raise money for proper clothes for Seacliff’s inmates.

Despite these attempts at reform, the asylum policy mainly lost sight of its original vision. The prevailing culture became one of hopelessness and containment rather than treatment and cure. This culture became codified and therefore “official” when Kraepelin used the fact that some patients did not recover sufficiently to leave his asylum as a *defining* feature for his concept of *dementia praecox* (forerunner of the term “schizophrenia”); and when Carl Jaspers used *un-understandability*, as a criterion for distinguishing neurosis from psychosis³. Since the environment within the institutions was so alien to life outside, and so disturbing to those who might visit, this culture came to include an officially-sanctioned lack of transparency and openness. So, in France, the accepted term for asylum attendants was “aliénistes”. Within that environment could grow a distinctly malign organizational culture which could thrive only in a closed environment. Hierarchies of power often flourished amongst staff, with the inmates themselves at the bottom of the pecking order, their voices, and those of their families totally ignored.

The extreme expression of this organizational culture was the atrocities of the Third Reich. Organised murder in the Nazi regime began with people supposed to be suffering from incurable genetically-defined disorders (mainly psychiatric). Of all professions, the medical and especially the psychiatric profession was involved more than any other. This could only occur in a prevailing culture of hopelessness, secrecy and connivance. This is not just history: It has touched me, and intersected with my own experience in several ways. At age 17 (in 1960) I viewed at a film society (it was not for public release) the documentary film entitled “*Nuit et Brouillard*” (“Night and Fog”), the footage taken by a French film crew when the concentration camp at Dachau was liberated. Six years later, at which time I was a medical student, I was committed to the main mental hospital in Sheffield. At that time this city probably had one of the more liberal mental health services anywhere in Britain, under the guidance of the former refugee psychiatrist, Professor Erwin Stengel. He undoubtedly knew about fascist medicine, and would have nothing of it. By

1 Hervey,N. (1986) Advocacy or folly: The Alleged Lunatics Friend Society, 1845-1863. *Medical History*, 30, 245-275.

2 Jones, K (1972) *A history of the mental health services*. Routledge & Kegan Paul, London, Boston.

3 Roth,M. (1963) Neurosis, psychosis and the concept of disease in psychiatry. *Acta Psychiatrica Scandinavica*, 39, 128-145.

1974, at which time I was myself recovering from another period of psychotic illness (involving a brief period in the Warneford hospital in Oxford), I attended a seminar in the Radcliffe infirmary there, on autism. During the presentation, the speaker voiced the view that, in her opinion, the stresses to which autism can lead within a family were so severe that consideration should be given to killing autistic children at birth. Obviously the speaker had no idea that anyone like me might be in the audience. I walked out in tears.

The enormous cultural shift now under way.

Jump forwards forty years. We are now in a different world. There has been vast progress in psychiatry on many fronts. Better biological treatments are available. Realization of the terrible harm often done by institutional environments has led to the asylum policy being abandoned in many countries, and the institutions closed. The delayed impact of the Nuremberg trials has gradually unfolded, and close scrutiny of ethical aspects of medical practice and research is now routine and mandatory in many jurisdictions. In parallel, there has been gradual strengthening and implementation of human rights concepts. Early realization that community care at its best was preferable to institutional care has led, in the last two decades, to widespread implementation of community care programs. Social programs and psychological treatments are now part and parcel of modern mental health services, along with biological treatments. In other words, the culture of hopelessness has shifted, not yet universally, but nevertheless on a wide front.

These are not the only shifts. Increasingly the voices of the consumers of mental health services are not only heard, but are actively sought by those who design these services. In the 1970s, the community pioneers were family members of those who were (or had been) in institutions. By the 1990s, it was those with lived experience of mental illness themselves who led the community campaigns. Today, many mental health services have positions of consumer advocates (and sometimes for caregiver advocates)

In response to these pressures the psychiatric profession itself is undergoing profound reorientation. Increasingly it is reaching out to the communities it serves. A degree of openness and transparency is coming to be the prevailing style, rather than the profession shrouding its activities in secrecy (as was often the case in the past). The policy of RANZCP in inviting community members on to its committees is a wise and courageous example of this process, whose impact is only just starting to be felt.

Despite all these positive developments, a major obstacle in the way of further progress, in my view, is the emotional legacy from the past. Many consumers hark back to practices which may have been influential some decades ago, or which they may have known only by hearsay. The film *One flew over the cuckoo's nest*, was made in the 1970s, about the 1950s, but is still a popular movie, seen, supposedly, to be of educational value about contemporary psychiatry. Unfortunately this unhelpful backward-looking gaze still gains support from contemporary practices, since demeaning and uncaring attitudes still exist in some services. My experience with consumer groups is that they are quite diverse, some consumers being grateful for the high quality care they have received, others embittered and hurt by poor quality care. Sometimes consumer activists appear to be deliberately stoking the fires of dissent. Overall, I believe that there is still a great deal of unresolved anger within community groups, rooted mainly in the past, yet still influential. This is likely to be the case for a long time to come. There are parallels here with another British policy implemented over the same period as the asylums – the workhouses. Although this policy was abandoned in the years between 1930 and 1948, until quite recently for many elderly British people as they reached their last years, fear of the workhouse was uppermost in their minds. The depth of unresolved anger about the asylums, in my view, is likewise a factor

which has to be borne continually in mind, as leaders of the relevant professions negotiate the transformation of mental health services.

When Emotions Run High. . . .

It is clear that emotions run high in the area explored here. Amongst the strong feelings may be ones which appear to conflict with each other. Some practitioners in institutions of former times may feel aggrieved and hurt that their efforts are so strongly and publicly criticised. It is not my intention to deny the validity of their viewpoint. Those institutions undoubtedly varied greatly. The whole scenario is a complex kaleidoscopic picture, not to be summed up by broad generalizations. Personal accounts which differ sharply from each other should seldom then be seen as contradicting each other, but rather as parts of a very complex whole.

I believe that the process of resolving hidden anger will assist the emergence of a “new psychiatry”. In part, this means addressing painful emotions. Metaphorically, this disquieting process represents the “birth pangs” of a new professional identity. The voices of past service users, and their family members need to be heard. Where those family members are no longer alive, accounts of their views, whenever they can be recalled, should be conveyed to those who *are* still alive. Also to be heard are staff who may have been corrupted or scarred by the institutional culture of the past, and whose emotions need also to be considered. In describing the symposium itself, and to assist the healing process, I believe it is necessary to describe a little about the emotions expressed by participants in the symposium itself, some of whom (myself included), being on college committees, are named.

Recent events forming the background to the symposium:

Personal note. I emigrated from Britain to New Zealand at Easter 1977. In the months after that the New Zealand organization calling itself “The Schizophrenia Fellowship” came into existence. In my first few years there, I was a member both of the medical faculty at Otago, and of the local branch of Schizophrenia Fellowship. This dual role was extremely difficult for me to handle, given my political inexperience, and my vulnerability at the time. I was, in a sense, developing a prototype role, now officially acknowledged as “consumer advocate” at the interface between a community group, and the mental health professionals. While I do not want to describe this in detail, I became powerfully aware of the inconsolable despair and anguish of the aggrieved families I was engaging with, experiences which I will not forget. My attempts to convey their viewpoint to mental health professionals were not only not heard: they were actively ignored, and I was systematically undermined. Despite initial apparent openness by those key professionals, I never penetrated their defences to discuss real issues; and I ended up being badly hurt. Details learnt more recently have helped me see these experiences in the context of the organizational culture of the time.

Radio Interview with Two Trainee Nurses, about Porirua. More recently two events formed a background to the symposium on Anger Resolution. These are mentioned below in the text of my introduction. I want to provide more detail on one of them, the radio interview with two ex-psychiatric nurses, since I have a tape recording of that interview. The Interview, on National Radio, New Zealand, on 12th July, 2004 was with these two ladies who, as trainee nurses in the late 1960s, were seconded for a period to Porirua Mental Hospital, north of Wellington. Since they were student nurses, rather than regular staff at the hospital, and posted there for only a limited period, they had no agenda, nor any reason to conceal what they experienced. One of the two, Elizabeth Gamien, was sent to a

general adult female ward, and described the “atmosphere of cruelty”, the ward being a place “for containment, not to get better”. “Staff were routinely drunk on duty, were neglectful and violent.” “There was nothing remedial, no form of rehabilitation”. She was shocked to find that no-one was concerned about such things. However, the ward atmosphere depended very much on the person in charge: Some, including senior staff, were callous, others were more considerate. Relationships amongst staff were far from collegial, but seemed to reinforce the brutal culture. A charge nurse is quoted as saying “Nurse Gamien, you’re not here to talk to the patients!” “As student nurses we could not contribute anything even in a small way and we were at the very bottom of the pecking order”. As a trainee nurse she was given the task of cleaning out padded cells after they had been soiled by patients, of putting violent people in straightjackets, and, despite her inexperience, she might find herself as the only staff member supervising large numbers of inmates during their exercise session. She also described the stress, as an inexperienced trainee, of being the sole person in charge on a night shift, responsible for administering powerful psychoactive medicines. On one occasion she had to accompany a patient who had broken her hip, taken in an ambulance to Wellington hospital. The patient stopped breathing during the journey, and she was expected to administer oxygen, although she had never been trained to do this. This patient died later on, after reaching the hospital: “I was not even allowed to hold her hand”. Showering for patients was “medieval”, with many bathed at once, and herded around, often naked. She did not witness sexual abuse or beatings, but the emphasis was nevertheless on punishment: “Tow the line – even in small issues – or else”. Threats of shock treatment or paraldehyde injections were used to enforce requirements. ECT was given unmodified, and “sometimes it took four of us to hold a patient down”. This caused great pain, and patients were terrified of it, not only because of the pain and indignity, but also because of its being used as punishment, and the memory loss. Some of the patients had been admitted for relatively minor problems, such as post-natal depression, but within a day or two were reduced to a terrible state by the medication. Before long, as a result of largactil treatment and sunlight, their skin became stained a brown colour. (In the courtyard, they often ran around naked.) They were medicated “so that they did not give the staff any trouble”. When Elizabeth Gamien detected that an elderly lady had painful sores in her mouth, as a result of largactil treatment, and brought this to the notice of staff, she was ignored. Many of the patients had had very hard lives even before getting into hospital. Elizabeth discovered that one lady had seen her son fall in front of an oncoming train. The harsh regime there reduced patients to a state of “profound hopelessness”. Elizabeth Gamien also had a period working at Sunnyside Hospital in Christchurch, two seasons later, and never saw anything there comparable with the Porirua experience.

The other nurse interviewed, Helen Talbot, had been posted to a geriatric ward, which included a number of people with Down’s syndrome. There, most of the time, there was profound boredom. The cruelty there was more subtle, but nonetheless cruel. When she tried to teach one of the Down’s syndrome people how to read, she was moved away from this possible interaction, which Helen perceived to be a form of punishment for her. Helen did not have to participate in administering unmodified ECT. However, she described an incident when a woman, with her arm held in an arm-locked was forced all the way down a corridor, screaming all the way. On another occasion, the whole ward was given laxatives, in full knowledge that the ward had limited bathroom facilities. Helen also described having to wash everyone’s dentures together, and then having to re-assign them to the right owner. Sometimes patients were unable to eat their meals, because they had the wrong dentures. Helen was afraid to complain. She also described the force-feeding of someone

who was restrained; and every time food was brought near the patient's mouth, who prepared to eat it, it was pulled away. People were treated like animals. "I was brought up on a farm, but I never saw animals treated so badly."

Another regular nurse at Porirua had been interviewed shortly before these two, and had said that such stories were made up, the result of hallucinations and delusions of patients; but Elizabeth stated "These things happened on a daily basis". She was disturbed that people doubted patients' testimony: "These people have come back from the Gulag". Conversations between staff members which she overheard, about goings-on in other wards, at first she could not believe, but on reflection interpreted as indicating that conditions and staff behaviour on the male wards were even worse.

The overall impact of what she witnessed led to a state of emotional numbness. "The only way to work was to anaesthetise your feelings". "It was corrosive: It wore away at every emotion I might have had." Her memories were "filed away", "put away in a recess so they would not come back to haunt me", to be recalled only a few weeks before the interview was scheduled. Elizabeth sums up her experiences as follows: It was only the semblance of a hospital. Staff wore uniforms, and gave out medicines, but otherwise it was a prison, a Gulag, with no evidence of any real medical attention. Even on the rare occasion when psychiatrists visited, their role as medical specialists was quite perfunctory. Elizabeth's over-riding message was "Listen and learn".

The Confidential Forum and the Report on it. In New Zealand the process of reconstructing mental health services started with the Royal Commission in the early 1990s, which reported in 1996 (*The Mason Report*)⁴. Many advances grew from that, including the government-sponsored *Like Minds Like Mine* anti-stigma campaign. Following increasing awareness of abuses in former asylums, as documented in the above two interviews, and much other testimony, a series of confidential hearing were held between 2005 and 2007. Several hundred former-inmates of the asylums had their stories heard and recorded. Testimony from relatives, and from former staff members were also heard (in much smaller numbers). The report on these hearings describes conditions in asylums in a generic way, to avoid anything which would identify individuals (patients or staff). In broad terms it corroborates the account given by Elizabeth Gamien and Helen Talbot. The report is referred to in my introduction to the Hobart symposium, and can be downloaded from the Ministry of Health website⁵.

Documentary films about asylums. In the wake of the hearings of the Confidential Forum, two documentary films were made, with Jim Marbrook of Auckland University of Technology as producer. The first, lasting about 35 minutes was released in 2006, and is entitled "A Town Like Alice"⁶. It features Lake Alice Psychiatric Hospital near Wanganui. Unlike most of the country's mental hospitals, Lake Alice in the 1970s was not run by the local Health Board, but from central government. The second, a longer film, 70-minutes in length, entitled "Mental Notes" was released in April 2012 and I saw its first showing in Wellington⁷. I count several of the people who speak on that film amongst my friends. It is expected that a DVD version will be made available after the film has had a round of

4 Mason, K. (1996) *Inquiry Under Section 47 of the Health and Disability Service Act 1993 in respect of Certain Mental Health Services*. Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley, Christchurch.

5 <http://www.dia.govt.nz/Agency-Confidential-Forum-for-Former-In-Patients-of-Psychiatric-Hospitals-Index>

6 Not to be confused with the Australian movie of the same name, based on a novel by Neville Shute.

7 The film "Mental Notes" was shown at the meeting of the New Zealand branch of RANZCP, on 20th September 2012, at "Te Papa".

cinema showings. The following paragraphs are based on notes I took during viewing these two films.

Both films have a similar format, dominated by former patients strolling through the grounds, and derelict buildings of now abandoned hospitals, trying to remember incidents in their former lives, and locate them in what is left of the wards. The people featured in the films are quietly thoughtful, not angry. None of them denied the reality of mental illness; and there *were* smiles, but such wry ones! Of course the people featured in these films were exceptional in that they came through their traumatic hospital experience unbroken in spirit. They are now part of the community of survivors, working to ensure that the right lessons are learned and that mental health care does not go down this track again. They are people of immense courage, and personal integrity.

We hear one former patient describing his arrival to hospital, finding himself in a seclusion room, after tranquilization/sedation, not knowing, how he got there. Patients were stripped of their humanity, even their sense of individual identity: They did not have their own clothes, only clothes from a communal collection. Small concessions to humanity had to be earned by conforming to required norms of behavior. The environment was dehumanizing as much for staff as for patients. At Lake Alice, many staff had been trained there and knew no other environment; and there was even some intergenerational continuity of staff, as though the profession ran in the family. Little wonder that these places were described as Gulags. We hear again of the trauma of day-to-day life. In one ward ECT was delivered to patients one after another in an open ward, staff moving with their equipment from bed-to-bed, the patients meanwhile experiencing growing terror. At one hospital ECT (unmodified) was used routinely as punishment – and indeed the equipment was sometimes used on people’s legs, clearly to cause pain, rather than to bring about a seizure. One former patient mentions deep sleep therapy lasting six weeks, after which, in great distress she found she had put on a massive amount of weight. Another mild-mannered ex-patient says “I learnt to be angry”. Medications were given with little apparent concern for side effects, although other patients might draw the attention of staff when someone was experiencing severe consequences, when other medications would be given to alleviate side effects. One person describes how, after receiving medications (presumably anti-psychotic) she was unable to walk backwards. Patients seemed to hate the very idea of drugs for the mind. Toilet facilities in seclusion rooms were inadequate or non-existent⁸. The trauma of in-patient care was so great, according to one former patient, that it led patients to avoid treatment after they had left the hospital, which sometimes led to another relapse. One former patient, a Maori lady, reported that she had been offered \$10,000 as compensation from the government. It is strongly implied that this was “hush money”

One psychiatrist, Dr David Codyre, who did visit Lake Alice and spent some time getting to know patients there said that most of them had not seen any psychiatrist for years. To receive a diagnosis was seen by one patient as “the end of the line”. Dr Codyre offered the view that the diagnosis of schizophrenia was at the “centre of the hub”, and everything else revolved around that. He nevertheless mentioned that, despite all the gloomy prognostications, most former inmates “moved on” after release from hospital: They got away from the institutional experience, found jobs and made relationships. “Even after many admissions, with the right support and care, they make it, and things improve”. He felt that much *has* improved since the times reported in these documentary films; but for the most difficult patients, little has changed for in-patient care. “Mental notes” also makes

⁸ I have heard a similar complaint, referring to the quite recent past for NHS psychiatric care in Britain.

the point that the harm done by mental institutions in New Zealand was known even as early as the 1870s. The over-riding message of these two documentaries was “the path to healing is acceptance that these things *did* happen”.

The Symposium Itself.

As one of a number of parallel sessions at the Hobart Congress, this symposium took place in the afternoon of Monday 21st May. There were five contributors, about fifty people in the audience, with Dr Rosie Edwards as facilitator. After the presenters had made their individual contributions, there were some very important contributions from the audience. The session was videotaped, and so the college has a full record of the event, and we used a roving microphone, to ensure that, in the discussion, everyone could hear contributions from the floor.

My introduction. I started the symposium dramatically, with no formal introduction. The text of my introduction follows: After a sharp “double tap” on the rostrum, to call the audience to attention, I began with a poem:

The Poison Tree

I was angry with my friend
I told my wrath; my wrath did end.
I was angry with my foe.
I told it not; my wrath did grow.

And I watered it, in fears
Night and morning with my tears,
and I sunned it with smiles
and with soft deceitful wiles.

And it grew both day and night
Till it bore an apple bright;
And my foe beheld it shine,
And he knew that it was mine,

And into my garden stole
When the night had veil'd the pole:
In the morning, glad I see
My foe outstretched beneath the tree.

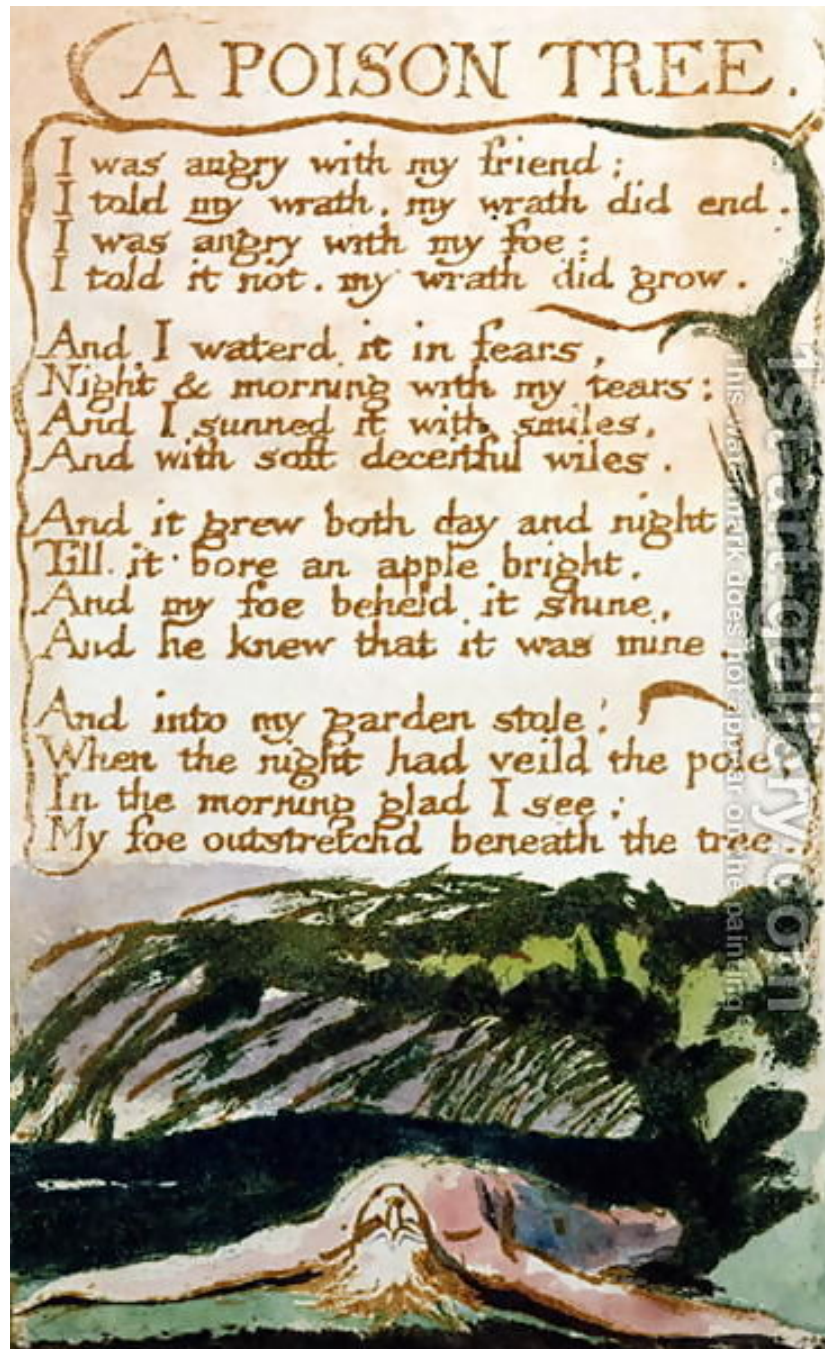
(William Blake: from *Songs of Innocence and Experience*)

(Blake’s lithograph – see below - for this poem: on screen through most of the rest of the symposium)

Pause

Broad smile

OK, OK, OK; Cool it, Chill out, Take it Easy, Calm down. In case you hadn't realised, those *were* emotions; *angry* emotions; but they were *feigned* emotions, an act. See – my hands have stopped shaking, my voice has become steady. Strange! (giggles).



Now, I'm not a trained actor; never been to drama school – so the fact that I can put on an act like that: Perhaps it shows that I know those emotions, for real now, and they are lying there not far beneath the surface.

That poem is part of a large set of poems of William Blake, collected together under the title *Songs of Innocence and Experience*, written between 1789 – the year of the French Revolution – and 1793. The poem I read - *A Poison Tree* – especially its first stanza, says a

great deal about the psychology of anger. If it is not expressed, it grows until it becomes poisonous in intensity. *That* is the theme of this symposium.

Fifteen years after 1793, in the year 1808, the British parliament passed an Act, decreeing that in every county there should be built an asylum for lunatics, mentally ill people, call them what you will. In due course that policy was implemented. Initially the asylums were better than what had been going on previously – mentally ill people locked away private madhouses and in back attics, as described in Charlotte Bronte's *Jane Eyre*. In due course, however, they became hateful places, overcrowded, sordid, often brutal, and feared by the general public. Once the policy had been implemented, it was extremely difficult to reverse, although by the middle of last century it was clear just how damaging that environment was for inmates. However the policy *has been* unwound, gradually in the last forty years in many countries. Yet the memory lingers on in public consciousness, and, I think will continue to do so, for a long time to come. In the aftermath, the psychiatric profession in many countries is in the process of re-establishing itself on a very different footing, reaching out to the communities it serves, and hoping for true partnership. However, a major obstacle standing in the way of such reform is the folk memory, and emotional legacy of those former institutions.

Just as an aside, I *have* been a patient. A long time ago I had two spells in hospital, for a psychotic illness, including one as a committed patient, but fortunately, I never spent any length of time in the sort of institution I have just referred to. Today, as a community representative for the College, I do a lot of travelling around New Zealand, to make sure I stay in touch with the grass roots. I also want to mention two incidents, ten or more years ago, which planted the seeds out of which this symposium has grown.

The first, over ten years ago, was when a distinguished colleague and friend retired from an important role in mental health. She invited her close associates to a retirement party. One invitee had actually been released from a forensic unit for the occasion; and when the party got going he started making loud angry noises; big trouble seemed to be brewing. Fortunately, there were wise people there who soon calmed him down. The following evening some of us gathered in my friend's living room, including a Maori elder – the kaumatua – of the tribe, the iwi, to which the person I just mentioned belonged. During the evening, the kaumatua stood up, leaning on his stick – he was a sick man, dying of cancer – and gave a formal apology for the behaviour of the man who had caused trouble the previous evening. He was not apologising on behalf of himself, but on behalf of his iwi – his tribe – on behalf of whom he spoke. "It should not have happened. It will not rest here" he said. That impressed me very much.

The second event, about the same time, was when I heard a radio interview with two elderly ladies, who, when younger, had been psych nurses at Porirua hospital in the late 60s and early 70s. They described the sort of abuse that went on at that time. They had something on their consciences to which they wanted to bear witness.

Both of these events speak of the power of a sincere apology. In the years since these two events, especially between 2005 and 2007, there has been a government-sponsored process of truth telling in New Zealand, when former patients at those institutions (several hundred), their family members, and former staff (in much smaller numbers) were given a chance to document their experiences. I have some copies here of the report on those hearings. In part this was based on the Truth and Reconciliation Commission in post-apartheid South Africa, although it was not in public as was the South African commission. As far as I am aware, nothing like that has happened in Australia, either at state level, or federally. Undoubtedly it helped many individuals on their journey of healing, and to put the past behind them. However, as in South Africa, many people in the service-user groups

were dissatisfied with the outcome; some wanted retribution. People I speak to say – as was said about the South African process – that there was some truth told, but, as a public process, there was little reconciliation. In any case, the parallel with South Africa is not exact. In psychiatry, there is not, and, I think, can't be, any sharp revolutionary change of regime, but rather a protracted, yet deliberate, even radical transition of organizational culture. So, rather than a big public event, or the private hearings that happened in New Zealand, what I think is needed is an extended process of discourse amongst the different stakeholders, working in relatively small groups in each locality, and perhaps going over the same ground a number of times, so that consensus may gradually emerge, and true healing can take place for all concerned. Nevertheless, those closest to the truth-telling process in New Zealand believe that a public apology *is* needed, not a personal apology, but an apology coming from government levels, perhaps also from the psychiatric profession, before resolution and healing can occur; and they also say that that is not possible until resolution *within* the mental health professions themselves has taken place, in their attitude to their own history.

There are a few more points I want to make here:

First, the policy of asylums was not all bad, and the community-based approach is not all good. In New Zealand I am told that in the country's prisons, the number of inmates with serious mental disorders – over 1000 persons - is roughly the same as the numbers in all the country's acute psychiatric wards. If treatment is available, it, and the overall environment, may be much worse than in many asylums of former days. Hardly a good advertisement for community care, although it may be New Zealand's justice system which is really at fault.

Second, as those two nurses showed, many staff of those institutions were, in a sense, also victims of a system which was far too big for anyone within the system to challenge. Former staff may be unwilling to see themselves in that light, although it is well documented in the report; but if we are talking about a process leading to healing, the door should be open for them too to participate.

Third, I want to address the wider range of professionals now running the mental health services. Some of you may already be adept at acknowledging past shortcomings of mental health services, allowing anger to be expressed, and facilitating the process of healing. Others perhaps still need to learn these things. In addition, in the present climate where community participation is increasing in its scope and influence, you may need to learn how and when to change gear: In one situation, in interaction with patients you deal with in hospital or in a consulting room, there is inevitably a great imbalance of power. I think it is realistic to be explicit about that, although many safeguards need to be in place to prevent abuse of power. However it may also be necessary for you to learn when and how to engage with community spokespersons, who may be the same people who were once your patients, regarding them now as participants in evolving services, entirely equal in status and rank to yourself, though having expertise in areas different from yours.

Lastly, let me tell you a bit more about my own situation. I'm in an unusual position. On this occasion, I seem to speak as an ex-patient, and a one-time academic and researcher; but amongst community groups I am often mistaken for a psychiatrist. So, let me describe the line I take in interacting with community groups – service users, caregivers and family members: Apart from detailed matters, I am likely to suggest ways by which they should try to deal with their own anger; and here I'm particularly addressing *spokespersons* for community groups, or consumer activists. I am likely to say that they *should* convey their anger, but they should not be inwardly consumed by anger. If they cannot get near to that approach, they are probably not ready for that sort of communication. The ideal, I believe, is that, as they convey their anger, they have an inner calm. Then, if the audience responds

positively, at a moment's notice they can change tack emotionally, and reciprocate with messages encouraging partnership and collaboration. That was what I was trying to model, in the way I introduced this symposium, using Blake's poem.

There are two things that I advise strongly *against*. First, anger should not be *personalised*, to become a vendetta against any individual, which sometimes happens. The Wind of Change which is blowing through psychiatry today is bigger than any of us, as were the social forces, which set up asylums in the first place.

. . . and, second, people should not make a career out of anger, as some do. In that context, I want to recount an episode after World War II. During the War, Wilhelm Fürtwangler was conductor of Germany's most prestigious orchestra, the Berlin Philharmonic. He was in disfavour in the immediate post-war period, because he was thought (wrongly, many now believe) to have been an active Nazi collaborator. As with many people of integrity in that regime, he found himself in an impossibly ambiguous situation. The violinist Yehudi Menuhin worked hard to rehabilitate Fürtwangler, which itself aroused criticism. On one occasion, Menuhin found himself playing to survivors from Belsen concentration camp. A heckler in the audience shouted angrily: "Go on, play for the murderers!" Menuhin responded with a brief speech, including these words: "I cannot blame anyone for his bitterness. You have suffered too much, you have lost parents, children, brothers and sisters. I have been spared this torture. And still I do say that you simply cannot rebuild your life upon your suffering." His eloquence carried the day, and he was received with rapturous applause. Issues in today's mental health sector are by no means as grim as those to which Menuhin was responding, but the principle is the same.

So, starting with that, let me introduce our other contributors: Kali Paxinos is a fellow-conspirator on the College's Community Collaboration Committee, and Carer Consultant in Victoria Mental Health Services; Jim Crowe, also on the CCC, and on the College's General Council, is a long-time advocate for the family perspective on mental health, and currently Chair of World Fellowship for Schizophrenia and Allied Disorders (Asian Region); Moe Milne is a member of the College's *Te Kaunihera*, committee, and consultant with *Te Moe Moea, Northland* (for Indigenous Mental Health and Addictions). If anyone in these parts knows about anger resolution, it is the Maori of New Zealand, the *Tangata Whenua* – the People of the Land. Then we have Anthony Weare, Clinical Nurse Consultant, from the Department of Psychiatry, Royal Hobart Hospital. It is important to include the nursing profession in this dialogue, because psychiatric nurses are often right at the coal face, where juxtaposition of their roles in control and care, and the need to reconcile the two, is most immediate. Lastly, we *must* hear from a psychiatrist, and on this occasion, from a College member. . . .and we are honoured to have in the panel Rosie Edwards, who chairs the New Zealand National Committee of RANZCP, and is Clinical Leader in Wellington/Capital and Coast DHB. She will now take over now as Chair, make her own comments, and then, in general discussion, act as a facilitator.

Moe Milne spoke next, from a Maori perspective. She is a long-time psychiatric nurse, who had practiced within the asylum ward setting, and had seen the transition to community care. She spoke about the need for staff to "forgive themselves" as they moved from asylums to community care. She mentioned that in the days of the asylums, they knew that the care they were offering was quite inadequate; and that she and her colleagues could more easily fulfill their role as nurses, after the more senior staff had gone home each day.

Kali Paxinos, spoke as follows:

Thank you, good afternoon to you all. There is a real beauty in reaching the age of the 8th decade. I'm already halfway into that decade with the pride and pleasure of seeing five great grandchildren. Telling you this is important because the topic we are discussing today

“Laying the Ghosts of the Asylum Era: Anger Resolution in Psychiatry”. Anger is not difficult for me to resolve. Old age has many virtues and an important one is to forgive. But to forgive we need to understand our anger, then develop the wisdom that can help us learn that anger is a powerful and destructive emotion.

I experienced that anger when I heard the following words from a psychiatrist. The year was 1985 “Your son has schizophrenia. It is a serious condition and if your son doesn’t take his medication as prescribed he will be admitted and treated in a psychiatric hospital. As the doctor led us to the door, I clutched my son’s hand. He was in his own world of paranoia and delusion and I was crying. I turned to the psychiatrist and mumbled the following “You will never take my son away and put him in an asylum. I’m his mother and I will protect him and I will nurse him until he is well again.” We walked to the car and all I could see before me was the image of my loving son crouched by a wall rocking back and forth talking to himself as depicted in the film “The Cuckoo’s Nest”. Also during that time I had seen a documentary on television of the inhumane treatment of young people in an asylum off the coast of Greece. These images were to haunt me for a long time.

For a week I watched this handsome athletic son of mine who had ambitions to be a physical education teacher look like an old man shuffling around the house dressed in his pyjamas and wearing his father’s dressing gown. He giggled and talked to himself. He pushed me away when I tried to hug him. He refused to eat the food I cooked for him. Why does my son behave this way, why does he say I’m not his mother? I must have done something wrong, I’m not a good mother. I blamed myself. I had heard stories that mothers caused their children’s mental illness. These feelings were so destructive “What will my relatives think, what will the community think?”

Those visions of the asylum haunted me. I watched my son’s every movement. I kept ringing the psychiatrist. He listened but he didn’t tell me what to do or how to respond to my son’s delusional talk. I wanted to help him get well and be as he was before this nightmare. I was to learn later that a reply written by the psychiatrist to our family doctor made the following comments in his letter. “Mrs Paxinos is an ‘Overprotective Greek mother’”.

As time passed I was to meet many mothers especially in my role as a carer consultant. They came from all sectors of our society, Anglo backgrounds to mothers from our culturally diverse communities and indigenous groups. Many blamed themselves, others blamed some kind of evil spirits etc. Recently I heard the story of “Tom” (not his real name). In 1965 he was admitted as an involuntary patient at a Victorian Psychiatric hospital. He described a ritual that occurred once a week at the hospital. A day was set aside every week. The treating doctor had a session with consumers and their parents, although more mothers than fathers attended. Tom described it as a most “Gruelling and Brutal Meeting”. The purpose of these meetings as he recalled them, was to humiliate your parents. He did however comment that his illness at the time may have influenced his interpretation of those meetings. As time passed Tom blamed his mother as the cause of his illness. His reason for continuing blaming her was “the paradigm of the time”. This was the time of the influence and sayings of the guru of psychiatry, Dr R D Laing. So it was from these sayings that I formed the idea that I was to blame for my son’s illness. For a very long time I always felt that the clinicians treating my son were judging me.

Thankfully I dealt with these feelings of blame. One day I closed my eyes while sitting in a comfortable chair, I cried for a little while, then I followed directions of the lecturer. “Think back” he said to a happy time you had with your son. Relive those memories. The memory emerged. I was sitting in an old rocking chair nursing my baby. Beside me was my husband playing the lilting sounds of a lullaby on his guitar. In front of us were our other

four children; they were playing card games. As my baby suckled at my breast and the milk flowed I was happy. I knew then that I was not to blame for his mental illness. That night I slept peacefully.

There was a time when I was 10 years old. The year was 1937 and my Aunt Maria was taken to the Psychiatric asylum a long way from her home. She had three children and couldn't speak English. I relived those memories of stigma within the family and community when my son was diagnosed with schizophrenia. There was a total lack of understanding of mental illness. Our whole family and community always talked about mad Maria. Doctors didn't explain her condition nor could they treat her to improve. She was in hospital for a very long time. In 1946 she was sent back to her village in Greece with her children, her husband choosing to stay in Australia. He didn't know what to do. She was 75 years old when I visited the village. Her two children had returned to Australia. Her relatives and the villagers ignored her. Even the local doctor avoided her. The stigma was stark. No one understood her condition. An illiterate lady from another village who helped Maria harvest olives was the only person she trusted. The experiences Maria had of the asylum treatment in Australia were profound and she had a fear that she would be taken away to the asylum on an island across the sea. "No one loved Aunt Maria".

Although today I want to allow the ghosts of the past to be buried it is important that new ghosts never appear again. My anger and the sense of blame has now passed and I welcome new initiatives in the treatment of mental illness. However there are still many attitudes in our society such as stigma that are making the lives of people with mental illness and their families very difficult. It is time that the ghosts of the past disappear and any anger that I and others experienced be resolved.

I hope that adequate funding be provided for research to find new ways to treat our people with serious mental illness. We appreciate the treating clinicians listening to us but please tell us how to speak with our loved ones so we can walk through the difficult periods with them. The asylums are now closed and we care for our people mostly in our homes. Let us work together. We need many things to change. As carers our role is immense and we need our communities to support us. As a society we need to love our people who experience mental illness. We all make mistakes but with new knowledge and compassion we will learn from these mistakes.

The following words were written by William Jordan. "Let us be glad of the dignity of our privilege to make mistakes, glad of the wisdom that enables us to recognize them, glad of the power that permits us to turn their light as a glowing illumination along the pathway of our future. Mistakes are the growing pains of wisdom. Without them there would be no individual growth, no progress, no conquest."

My anger has passed and I'm so grateful to all the clinicians who have helped my beautiful son reach a stage of recovery where today he can give me such a big hug.

Thank You

Jim Crowe, is well known to college member, and spoke on *The Family Perspective*. He presented as Power Point slides a number of verbatim statements and expressed attitudes he had heard and experienced and over the years. Some of them were too hard emotionally for him to read them out loud, so the audience read them on screen. He spoke of how family members experience loss of hopes and expectations for their sick relative; how they come to feel that the person they knew has been changed by the illness. "Anger, anxiety and guilt expressed by family members must be dealt with in a sensitive way." Anger can usually be reframed as showing concern. Caring for someone with a mental illness exacts an emotional toll. Anxiety and depression are commonly found among family carers and should not be neglected. They are symptoms which reduce carers' capacity to support a

patient who is a member of their family. Their grief needs to be acknowledged, and they need help in coming to terms with their sense of loss. When this does not happen, families can become stuck and lose respect for clinicians, mainly because of lack of trust. When conflicts stemming from antagonistic relationships arise, clinicians need to listen to the differing viewpoints impartially and seek resolution through compromise.

Sometimes however clinicians' comments displayed gross insensitivity, verging on callous disregard of family members' feelings: Jim specified an instance where families were told by a clinician that "to think of the person as being dead." "Now that your person has a mental illness he will never be able to achieve anything, so don't expect too much." "Unfortunately the diagnosis is schizophrenia, now before you take him home we should talk about the threat of suicide as there is a possibility of it happening at some stage." "Thank you for bringing the person into the ward, we will look after the person - Now you can go home." Discharge Planning/Meetings were sometimes not adequate or non-existent: "The hospital can ring up and tell you that your family member will be discharged and you have no say in the matter."

If a more considerate approach is adopted, it can help everybody. "A major strength is the family's intimate knowledge of the person and what they have learned through a process of trial and error." "Concerns of families need to be valued and responded to in an atmosphere of respect." "Their own 'lived experience' can offer insight into the patterns of illness. Support, understanding and advice from professionals *can* make a difference to the outcomes of treatment, but listening with respect means so much to a family, and can help clinicians deliver better care.

Anthony Weare. (Clinical Nurse Consultant at Royal Hobart Hospital). Quietly-spoken, and thoughtful, Anthony did not challenge anything said by others, but generally spoke positively about his time as a psychiatric nurse. He described how he began work as a ward aide in the mid 1980's, with the intention eventually to train as a psychiatric nurse (now called Mental Health Nurses), which he did in the 1980s. The gender ratio at that time was about 50/50 (compared to in general nursing, where there were 95/5 females/males. Since 1991 Mental Health Nurses have been recruited from the general nursing pool which has resulted in a steady rise of female to male ratio.

"The psychiatric hospital where I trained was located 20 miles from town; it was never my intention to remain there post-training as I lived in the city. I understood the historical reasons for the location of the hospital but still thought that a smaller version was needed in the city. Clearly the hospital catered for too many different groups of patients - organic brain diseases, intellectual disability and chronic alcoholism - who should have been housed separately. I left after I completed training. I had been there for nearly 6 years. Some wards were good to work on, others were not. It was reliant on the quality of the staff leading the ward. I had good relationships with the patients there; I still have good relationships with patients I nursed at the psychiatric hospital.

Chronically mentally ill patients (with Schizophrenia, or Bipolar Affective Disorder) were 'housed' there. I am unconvinced that housing for these chronically mentally ill have improved now. People with these chronic mental illnesses can sometimes take 6 months and longer to stabilise (especially untreated schizophrenia). Facilities that exist here now do not have the capacity to house those people for that period of time. I am unsure but expect that if the psychiatric hospital existed now, it would be run with similar policies and procedures that exist in acute mental health settings now.

I remain unconvinced for the need to apologise for the system. I and most the people I have worked with tried to do the best they could with the facilities and resources they had. I still do my best in the acute unit where I work now. There were 'system problems' then and

there are system problems now. The origin of the severely mentally ill patients is unchanged as far as I know; a combination of genetics and various early traumas (emotional, physical and sexual), loss, neglect etc. Usually, seriously mentally ill patients do not believe they are unwell. I don't believe that has changed over time.

Patients, who are having an existential crisis, have a series of significant life stressors or a difficult personality (or a combination of either) generally do not stay in the system for long. That was the same then as now, though there may have been exceptions then.

Long-term patients at the psychiatric hospital generally had little or no family support. I thought then it was to do with the isolated location of the hospital and the stigma of mental illness - and it may have been in some cases. I see now the gradual withdrawal of family support, over time, in current patients as their condition causes re-admissions.

The social stigma surrounding severe mental illness in the community appears to remain as powerful now as it was when I began in the psychiatric hospital nearly 30 years ago. The training of Psychiatric Nurses I believe was more therapy orientated in the 1980's than now. We were paid to train and had regular intervals of clinical experience in various settings. We were taught how to run therapeutic groups, use of the therapeutic 'self' and the importance of therapeutic milieu. Now the nurse/patient ratios are higher and the focus is on the 'episode of care' and the accompanying mountain of paperwork that is scrutinised by an army of 'clinical governance' and 'quality and safety' overseers. Therapeutic time with the patient is the casualty. I apologise to patients frequently for that.

Anthony had never seen the sort of abuse that others spoke about, but regretted the fact that in today's world there was less time to spend with patients in his care. Several people from the audience commented afterwards felt it would have been good to have heard more from him.

General Discussion. Just as important as these presentations was the discussion which followed in the last 35 minutes of the symposium, when some heart-felt contributions were made by the audience. These include discussion about the rights and wrongs of locked psychiatric wards (with opposite views expressed by past service users), and a strong statement from a lady in the audience who had been in asylums in Victoria. This person echoed everything referred to in "Mental Notes", about abuse and organizational culture in asylums in New Zealand. Most impressive was the psychiatrist Wayne Miles (chair of our Community Collaboration Committee). I have known him a long time, but have never before heard him speak with such passion. He spoke of his days (early 1960s I think) when in Dunedin as a medical student, the psychiatric wards were shown to them as some sort of "zoo", and he recalled his later terrible experiences as a young psychiatrist at Carrington Hospital in Auckland. Wayne is a sensitive man; those early experience have left him scarred - there is no other word. Altogether this session brought out into the open topics which, in the College, are rarely discussed. This is important for the process of healing (both for former inmates of the asylums, and for the college itself). One point is regretted, that there was not more input from indigenous peoples in either country (apart from Moe Milne). I did my best to encourage them to join us, but they had a session occurring at the same time, which was unfortunate programming. The other thing to add is that the wisdom of the college in letting an event like this happen should be acknowledged. The Royal College is on the move, and in a good direction. Even in the three years that I have been on their committees, I have seen definite improvement, although it may take some time before that is evident to many people in the wider community.

Technical Issues About Diagnosis and Treatment

Several quite technical issues are implicated in the abusive practices referred to above. Some are about forms of treatment (both ECT and medications); some are about diagnoses. The treatments were developed in the heyday of the asylum era, and their potential for misuse is closely linked to the organizational culture which flourished in psychiatry at that time. It is therefore thought appropriate to go into some detail on these matters.

Misuse of ECT: ECT was developed in the 1930s, as a means of producing convulsions which was more reliable and controllable than seizures induced chemically (for instance using metrazol). Its initial use developed after resolving safety issues, based on animal experiments. This led to electrical pulses being applied directly to the head, rather than across the whole body (which could cause cardiac arrest). The idea of producing seizures was initially intended as treatment for schizophrenia; but after the method came into use it was found to be more useful for severe depression. “Modified ECT”, using short-acting barbiturate anaesthesia and muscle relaxants, was first used in 1951, this producing a cerebral seizure, but with a much-reduced physical convulsion. This quickly became the routine procedure (and it was used in this form when I received ECT in 1966 in Sheffield). Today ECT *is* known to be effective for severe depression, sometimes dramatically so, but only in a proportion of cases. It is not possible to predict who will respond, and the fundamental mechanism of therapeutic action of ECT is still not clearly resolved. It is probably related to production of seizures, rather than passage of electrical current through the brain *per se*. ECT usually causes a degree of amnesia, which is occasionally severe⁹.

Clearly use of ECT in unmodified form in the 1960s-1980s was archaic practice. To use it as punishment (e.g. on the legs) was way beyond the intentions of those who developed and used the method up to then. Indeed, use of large electric pulses on the trunk area of the body may be life-threatening (with risk of cardiac arrest). Details of the way ECT was applied showed no regard for feelings of terror which its use produced in patients. Maybe when uneducated practitioners heard the phrase “electric shock treatment” rather than “electroconvulsive therapy”, and if they had heard “on the grapevine” of experimental use of electric shocks as aversive stimuli in animal conditioning studies, they might actually have thought that their job on the ward *was* to use electrical shocks as aversive stimuli. Such use was however way beyond ethical norms for any medical practice or caring profession. That powerful electric shocks can so easily be misused (and have been misused) to produce pain rather than seizures, and the somewhat barbaric concept of producing seizures to treat a mental disorder, has led to the treatment being controversial, and tightly regulated in many jurisdictions. This tight regulation of ECT is now more a function of the history of abuse in each country than of its inefficacy and real safety risks of the treatment, as currently applied. However, here I am leading up to a section entitled “coming to terms with history”. To that end, I ask: What was there in the attitudes of staff, and indeed in their training (if they received any) which allowed such abuses to happen?

Antipsychotic medications were discovered accidentally in the early 1950s in a research program by the French drug company Rhône-Poulenc searching for medications to alleviate post-operative shock. This led to the discovery that chlorpromazine (largactil) had what appeared to be specific antipsychotic effects. The acute motor side effects of this medicine were known almost immediately, and by the end of the 1950s, the first reports were published of longer-lasting motor side effects, now called “tardive dyskinesia”, resulting

⁹ One of the first to draw attention to this was E. Stengel (1951) “Intensive ECT”. *British Journal of Psychiatry* 97, 139-142.

from longer periods on such medications. Janssen pharmaceuticals had by then introduced haloperidol, and a number of other drugs with similar activity were introduced by this company in the 1960s. By the late 1970s, it was also documented that for some people receiving these medications for any length of time, the dose needed to keep a psychotic disorder under control needed gradually to be increased. In some cases, patients might become completely unresponsive to standard medications, and then suffered from a state of psychosis unresponsive to usual medicines. However, by the late 1980s it had been proven that the antipsychotic drug clozapine (whose use had been stopped in the late 1970s, because of the risk of a serious blood disorder), was actually effective in controlling many such cases of “refractory psychosis”. Since then, after clozapine was reintroduced (with a regime of mandatory blood testing at regular intervals), many patients have benefited from this agent. It is now accepted that this agent acts in a different way from most of the older neuroleptic drugs; and correspondingly there is a class of psychotic states which is different from the normally-responsive ones. Sometimes, it appears, extended treatment with the standard neuroleptic drugs leads patients with an initially-responsive psychosis, to one which will only respond to clozapine.

The mechanism underlying tardive dyskinesia, and neuroleptic-induced supersensitivity psychosis is not the point here. The point *is* that these difficult-to-treat, largely irreversible syndromes are likely to be related to the dose of neuroleptics prescribed. How *did* psychiatrists determine the dose to be prescribed? Largely, it seems, from recommendations of the manufacturers. There are suggestions (never been followed up or properly defined) that the optimal dose of any neuroleptic for treatment of psychosis varies over at least a ten-fold range (from the most to the least sensitive patients), and perhaps over a twenty-fold range. Dose-finding trials by pharmaceutical companies almost always report results in aggregate fashion (that is, as response on rating scales averaged over a number of patients), which provides no data on differences in individual sensitivity. However, in the mid-1950s, the German neurologist-psychiatrist, H.J.Haase suggested that the right dose for each patient was that which produced the slightest detectable parkinsonian side effects. Being a neurologist, he used a sensitive handwriting test, unlikely to be used by psychiatrists outside the German-speaking world. His early publications on this were in German, but in the mid-1960 he published a book on his “neuroleptic threshold” concept, written in English, with P.A.J.Janssen as his co-author. (Janssen was obviously acutely aware of the highly unpleasant side effects of drugs such as haloperidol: It was at Janssen pharmaceuticals that the pioneering research was done to develop the first “atypical” antipsychotic drug, risperidone, in order to retain the antipsychotic effects without the motor side effects.) However, the publication of the book by Haase and Janssen had no discernible impact on prescribing habits. As a result, for many years after, antipsychotic drugs were prescribed in much larger doses than recommended by Haase’s method, and not adjusted for individual sensitivity. The full magnitude of the harmful effects of prescribing excessive doses of antipsychotic drugs is difficult to calculate, but is likely to be very large. A paper by J.P.McEvoy et al in 1991¹⁰, showed, nevertheless that Haase’s approach was mainly correct. The documented use of largactil in New Zealand asylum patients (so that their skin became pigmented¹¹), as well as severely disabling acute side effects suggests

10 McEvoy, J.P., Butner, N.C., Hogarty, G.E., Steingard, S. (1991) Optimal dose of neuroleptic in acute schizophrenia: a controlled study of neuroleptic threshold and higher haloperidol dose. *Archives of General Psychiatry*, 48, 739-735.

11 Satanove, A. (1965; Pigmentation due to phenothiazines in high and prolonged dosage, *JAMA* 191, 263-268) reports that such pigmentation did not occur until the dose of chlorpromazine, maintained over many summer months, was at or above 800 mg/day.

that over-dose of these medications was widespread there. Even in today's world, I am concerned that doses are often too high, and not adjusted to individual sensitivity. Part of the evidence on which I base my concern is personal experience. In the early days of my taking antipsychotic drugs, they were prescribed in a thoroughly wooden fashion, with little apparent understanding of what they were doing to me in terms of side effects (especially sedation). Perhaps that clinician's real worry was that florid psychosis might return; or to be specific, he was *afraid* of this. Of course, an attitude of fear on the part of a clinician is not helpful in forming a therapeutic relationship, but that seemed to be a hope that was nowhere in sight. When, a few years later, I realised I had a significant but manageable mental health issue, I discovered, by my own somewhat risky experimentation, that the dose of thioridazine which suited me best was one sixth to one eighth of what I was prescribed. Today many psychiatrists *do* know that once the dose of an antipsychotic drug is above the individual threshold, the unfolding of the therapeutic process is more a function of time at that dose than of the dose itself. I had worked this out by the mid-1970s; but I suspect there are still many psychiatrists who do not grasp this important principle.

This leads to hard questions: Why has it been so difficult to achieve proper dosage regimes in prescribing these medicines? Does it reflect marketing pressure by many pharmaceutical companies, lack of scientific acumen on the part of prescribing doctors, or simply attitudes to patients that, for people with severe mental illness, unpleasant, disabling and sometimes irreversible side effects don't matter?

Anti-Depressants. These medications were developed in the mid-to-late 1950s, in association with early research on monoamine transmitters. The first such medications were inhibitors of the enzyme monoamine oxidase, the enzyme which normally inactivates monoamines. By the late 1950s, imipramine ("tofranil") was introduced. It had a different mode of action, the slowing of the "pump" in the outer membrane of nerve endings, by which these transmitters, after release in active form, are taken back into those nerve endings. Both classes of antidepressant drugs thus exaggerate and prolong the actions of the monoamine neurotransmitters.

The early history of imipramine is described by Battegay¹². This compound was developed by Geigy in Switzerland. Initially it hoped to be "another chlorpromazine". As a result its first use was in schizophrenia. The very first observation in humans was *not* that it had an antidepressant effect, but that it converted depression (in schizoaffective patients) into mania. This is very significant, because one of the hazards with antidepressant drugs is an "activation" syndrome, sometimes likened to either mania or akathisia. This can be truly dangerous, leading to suicide attempts and other signs of severe disinhibition. My current understanding is that when this occurs, it is usually in patients with a bipolar rather than a unipolar mood disorder. However, since depression is usually the predominant, and first indication of a bipolar mood disorder, the realisation that someone has a bipolar rather than a unipolar disorder may not come until, out of the blue, they become floridly manic while on antidepressant drugs. I understand that this activation syndrome is more common with tricyclic antidepressant drugs such as imipramine, than with modern antidepressants such as the SSRIs, but still occurs with them too. Potentially it can have disastrous consequences, and in 1966, I myself experienced the very sudden transition from deep depression to florid mania while on tricyclics. Today it is one of the chief concerns in use of antidepressants, and has been the subject of major litigation.

12 Battegay, R. (2000) Forty-four years of psychiatry and psychopharmacology. In D.Healy *The Psycho-pharmacologists* Vol 3, 371-394

This leads to more hard questions? Why, given the very early knowledge of this activation syndrome, did the use of antidepressants spread so rapidly? Why was there no concern, and further research about the dangerous situation which might arise from this syndrome? Again, I ask: Does it reflect marketing pressure by pharmaceutical companies, lack of scientific acumen on the part of prescribing doctors, or simply an attitude that, for people with major mental illness, unpleasant and dangerous side effects don't matter?

Deep sleep therapy in Australia, New Zealand and elsewhere. The history of deep sleep therapy can be found in several books¹³ and official reports. To my knowledge something like deep sleep therapy was initiated under Eugen Bleuler at the Burghölzli clinic in Switzerland in the 1920s. Extended narcosis was also used for soldiers profoundly traumatized in theatres of war during WWII, and sometimes also for highly stressed civilians at the same time. It may still be in use in such situations. Its use as "treatment" for schizophrenia was developed in the early 1950s at the Allen Memorial Institute in Montreal¹⁴, and was also used on psychiatric patients at St Thomas's Hospital, London. Later, it was also used at the Chelmsford private hospital, in New South Wales (where over 30 people died during its use), and in several centres in New Zealand (most intensively at Cherry Farm hospital, north of Dunedin¹⁵). A version of deep sleep therapy was also in use in the 1970s at Ashburn Hall¹⁶, although it is unclear whether it was similar to the method used in the other centres mentioned. The procedure varied in different centres. Generally it involved prolonged barbiturate anaesthesia (with sodium amytal), and polypharmacy with a variety of psychoactive medicines. Sometimes it involved repeated use of ECT as well as prolonged narcosis. To put this in the context of the times, the best method for ECT use was a subject of active research in the 1950s, and at that time some practitioners advocated "intensive ECT"¹⁷. The persons under whose authority this procedure was carried out were usually leaders of the profession at the time. They included Ewan Cameron, founding president of the World Psychiatric Association, William Sargant, a leading psychiatrist in Britain in the 1950s-1970s, and Harry Bailey, a leading psychiatrist in Australia at the time. It is not clear who had ultimate authority for the use of deep sleep therapy in New Zealand.

It is difficult to discover any scientific rationale, or research behind this method for treatment of schizophrenia and other serious mental disorders. As Mellsop and Radford write, in their report on use of this method in New Zealand¹⁸ "The justification was based on faith in Sargant's reputation and not on available research". "Reports from the London-based St. Thomas's group through the sixties and first half of the seventies were influential, because of the authority and respectability of these advocates, and because they were able to publish in the British Medical Journal, and the British Journal of Psychiatry". Use of deep sleep "therapy" at the Allen Memorial Institute appears to have been therapeutic in intent only as a "cover" for other intentions: Cameron's work was financed in part by the

13 Anne Collins: *"In the Sleep Room"* Lester & Orpen Dennys, Toronto; Alan W, Schefflin and Edward M Opton (1978) *"The Mind Manipulators"*, Paddington Press, New York.

14 In one period of study leave, in the early 1990s, I spent several months working at the Allen Memorial Institute, and had access to files in their "record room". Occasionally I came across handwritten notes signed by Cameron, from memory, I think, sometimes recommending "sleep".

15 *Report of Graham Mellsop and Michael Radford as sought by the Department of Health into the use of "Deep Sleep Therapy"*. Department of Health, New Zealand, 1991.

16 Personal testimony to the author from one recipient of such treatment.

17 "Two to four shocks on successive days over a period of a week or two" (Stengel,E. [1951] Intensive ECT. *British Journal of Psychiatry* 97, 139-142.)

18 *Report of Graham Mellsop and Michael Radford as sought by the Department of Health into the use of "Deep Sleep Therapy"*. Department of Health, New Zealand, 1991.

CIA, who wanted to learn more about techniques of “brain washing”, and the method was conceived as a technique for “reprogramming” peoples’ minds.

In the report of Mellsoy and Radford it is suggested that use of deep sleep therapy in New Zealand probably derived from Sargant’s use of it in London. However, the narcosis was more prolonged than in Sargant’s reports. It was used far more widely across diagnoses at Cherry Farm, compared to St Thomas’s, and sometimes *with* little selectivity over diagnoses. Polypharmacy and prolonged barbiturate anaesthesia were not considered acceptable practice at the time. Again hard questions arise. Do we know that deep sleep therapy as used at Cherry Farm was inspired by Sargant’s work? What is the evidence? If not, what *were* their overseas contacts in the psychiatric world which informed them, and led to its being used in New Zealand? Under whose ultimate authority was this form of treatment allowed? What professional attitudes led to it being used without a proper research base? What were the objectives behind its use? Mellsoy and Radford write: “The only documented evidence suggests that Dr X (the redacted “name” of the doctor in charge at Cherry Farm), and the other hospital staff were doing what they considered good for the patients.” However, since the method seems sometimes to have been used with scant regard for diagnosis, I ask, whether the objective was really therapeutic, or rather, that the supposed “therapy” was a cover for something else?

Diagnosis. Underlying all these examples of incorrect use of accepted therapies, and inappropriate introduction of untried ones, is the hardest of the scientific imponderables: Our concepts of mental disorder – of the different types, and generically even of “mental illness” itself – are by no means established by acceptable scientific reasoning, as would concepts in physical sciences or concepts of disease in general medicine. In other words, at the most fundamental level, it was not understood what is mental illness *per se*, and we cannot give meaningful definitions which will stand the test of time of any of the subdivisions of mental disorder. This comment in no way is meant as criticism of the psychiatric profession. It is the reality we face. In any field, issues of concept validation are the most difficult of all, ones without which no field of enquiry can have a firm base for its development. I will argue in the next section (“Coming to terms with history”) that *this* is the dominant factor underlying abuse in psychiatry, though we seldom admit it. This, to use a current metaphor, is the “elephant in the room”.

Comment Apart from deep sleep therapy the above styles of treatment arose from accepted therapies, developed on the basis of at least *some* research, and with at least *some* indication of the diagnostic specificity of each treatment, in so far as diagnoses at that time allowed such specificity. However there was in each case a degree of serendipity in their emergence as treatment for specific types of mental disorder. There also appears to have been bland disregard of side-effects, sometimes very serious ones. Today, each of the three treatments - ECT, antipsychotics and antidepressants - do have a place amongst today’s treatments, especially for depression and psychotic disorders. Going further back in history there is a long succession of sometimes barbaric treatments that have been tried within asylums, generally without any semblance of a research base. Deep sleep therapy appears to fall under this category.

The period when these three emerged – the 1930s to 1950s – was also the time when modern concepts of medical ethics were emerging in the aftermath of the Nuremberg trials, but those concepts were by no means entrenched as established routine requirements when new therapies were being developed. We like to think of the modern insistence on rigorous ethical scrutiny as progress, with implicit criticism of practices of the past; but is this fair? Given the stark realities of the environment in asylums of former days, what *should* a conscientious, if desperate clinician have done to alleviate suffering of patients in his/her

charge? There was very limited understanding of the nature of mental disorders, even at the most fundamental philosophical level, and approaches to treatment could be based on widely diverging assumptions, even fundamentally opposed world views. Even today, our knowledge of cerebral mechanisms is hardly ever well enough advanced to recommend new treatments on a rational basis, related to tested theoretical concepts (as might occur when new physics-based technology is under development). Inevitably, new treatments arose mainly on an empirical rather than a rational basis. These remarks are directed here to development of new treatments in psychiatry, but they also undoubtedly applied within general medicine, though at an earlier historical period: The present-day state of usually-sophisticated medical technology, arose from a past world of practice where ethical norms were very different and less strict than those in use today. Throughout medicine effective treatments still in use came from that era and by such flawed approaches. Occasionally, in the scientifically more advanced areas, progress in treatment has come about by a truly rational approach. One of the first examples of this was provided by Pasteur, who, it should be noted, was trained in the physical sciences, not primarily in medicine. However the first steps in the transition from proto-scientific to scientific medicine are rarely so rational

Add to all this, was the assumption of hopelessness which, in some sense, must have prevailed within asylums of former years. What should clinicians have done? Although most modern ethical precepts became codified in legal statutes only post-World War II, conscientious clinicians no doubt were aware of ethical guidelines and constraints on their practice long before that; yet in the dire situations in asylums, there was profound suffering all around anyway, which doctors in charge could not alleviate. So, in context, treatments which today we find cruel and barbaric may not have appeared so in those days. Even today, when a new life-threatening medical crisis arises, ethical guidelines can be relaxed. I think here of the emergence of HIV/AIDS around the year 1980, and the remarkable story by which relatively effective treatments were developed before the turn of the century. In this case, it is notable that political pressure to relax ethical guidelines for new treatments came primarily not from clinicians, but from community activists, representing those who were at risk¹⁹. This is not the only instance where idealised ethical guidelines are relaxed: In developing a new pharmaceutical, initial clinical trials cannot possibly reveal all possible side effects, given the diversity of responses to a new drug which might appear idiosyncratically in a small minority of those for whom it is prescribed. So, the research phase continues long after the public launching, marketing and large-scale prescribing of a new product. In a sense this transgresses the ethical requirement that patients give fully informed consent; but in a different sense it reminds us that ethical precepts cannot be set in concrete, as immutable precepts despite changes of circumstances.

So, with evidence in mind of apparent abuses of psychiatric treatment in the asylums, documented above, I ask another hard question, perhaps harder and more critical than any asked in the preceding section: What, if anything, was going wrong there? In the report of Mellsop and Radford, on deep sleep therapy, the authors write: “Ultimately, the test of whether a treatment is appropriate is ‘Was it safe and effective?’ but for psychiatry, where basic understanding was (and still is) limited, the authors immediately qualify this with the statement: “In such an inexact science it may be difficult to decide if the treatment helped the patient.” Moreover, in the asylums of former days, with suffering all around, the

¹⁹http://www.fda.gov/ForConsumers/ByAudience/ForPatientAdvocates/HIVandAIDSactivities/ucm134331.htm#_Toc2o5VA5Y_email. Martin Delaney was the HIV activist who led the community campaign to persuade the FDA to change its procedures.

criterion of “safety” becomes somewhat relative. So, again, I ask, what, if anything, was going wrong in the evidence documented?

Coming to Terms With History.

History is not just about the past, and it is not just an academic exercise. It lives with us in the present, it defines what we are today, and what we might become in the future; but we have to come to terms with it. How can we do that? I refer here not just to knowing things about which individually or collectively we might feel proud, but also to reconciling ourselves to darker things in the past, for which we may have little personal responsibility, but which collectively, and as members of enduring organizations or societies, we still do bear responsibility. Coming to terms with history need not mean casting judgment on those dark chapters. We may know the aphorism “To know all is to forgive all”, which is more accurately translated as “To *understand* all is to forgive all”²⁰. The more we understand what went on in the past, the underlying attitudes of key players, and the organizational cultures which prevailed, the less need is there to pass judgment. To greater or lesser extent we all have the potential to display those regrettable attitudes, and to contribute to those toxic organizational cultures. They are perennial aspects of human nature and human societies, surfacing from time to time in each historical epoch. The more we understand them and the more we realise our own vulnerability, and capacity to participate in their re-enactment, the stronger the safeguard that they will *not* recur on our watch.

Our ethical perceptions deepen as we grow older. Young people – medical students, trainee nurses, for instance – are not usually very independent-minded in their ethical judgments. They are strongly influenced in their ethical behaviour by their role models, those who are more senior than them. When dubious practices are clearly everyday routine, which of us, as junior staff members in institutions with their own powerful organizational culture would be able to resist the pressure to conform? With this question in mind, it is clearly the role of leadership in a profession to set exemplary standards for ethical behaviour; and if a system of health care is found lacking, it is the people at the top who should carry the can, not mainly their underlings. However, as argued above, ethical norms for medical practice and research are not “set in concrete” as permanent guidelines, but need adjustment from time to time, and according to the urgency of each situation. Those with longest experience, it can be argued, are best placed to strike a judicious, if impressionistic balance between opposing pressures. It might be argued, that decisions to “bend” those guidelines to match the situation, should also come from leaders of a profession. In medical professions, decisions are often taken in the face of uncertainty, routinely in the case of decisions about individual patients, and sometimes more generically when advances in treatment, or new conceptual approaches are under development. In this sense, given the inevitable uncertainties, those leaders need a degree of protection from future critics, when many uncertainties have been resolved, and adherence to stricter ethical codes becomes mandatory.

This appears to be an argument *in support of* the personal authority of leaders, and *against* the role of principled whistle-blowers. However, the evidence documented above reveals professional attitudes which should *not* be protected. These included at times,

20 Germaine (“Madame”) de Stael: “Tout comprendre rend très-indulgent”. No doubt this comment reflected the fact that Madame de Stael lived through the turmoil and brutality of the French revolution.

deliberate and intentional cruelty. Sometimes environments were constructed, and practices deliberately designed to undermine patients' sense of personal identity. Sometimes this should be attributed not to individuals, but to the culture and staff in each ward, and sometimes to misuse of treatments, both biology- and psychology-based. Moreover, the leaders of the profession were clearly *not* setting the standards: They were notable by their near complete absence from the asylum environment. To get to the root of such malpractice, we need to understand the organizational culture.

Understanding the culture of hopelessness. Elizabeth Gamien described how patients at Porirua were reduced to a state of "profound hopelessness". One might imagine the portals of such institutions welcoming their inmates with the line from Dante's "*Inferno*": "Abandon Hope All Ye Who Enter Here." How can we grasp the fact that such environments should masquerade as hospitals? Underlying all the shameful practices and attitudes, was, I believe, the profoundest *lack* of understanding, at a level which was both utterly fundamental, and also highly personal: The facts of severe mental illness challenge our basic assumptions of what a person is or can be. This has been a dominant fact over many centuries, as societies have tried to deal with mental illness in their midst. When we are challenged so deeply and so personally, for many of us, our instinctive reaction is one of *fear* of what we do not understand, followed shortly after by *denial*. Together, incomprehension and fear are the roots of the culture of hopelessness, which culture, in the asylums became all-pervasive, closely related to the unassailable assumption that once patients arrived there, there would be no going back to normal society. Developing from that all-pervading culture, the primary objectives inevitably shift from treatment or cure to "containment" and "management". The idea that there might be really effective treatments recedes beyond the horizon.

As explained above, authority (personal and institutional) has, for understandable reasons, been part of the culture of the medical professions from time immemorial. However in the asylum culture, the cult of personal authority becomes stronger, since the main alternative source of authority ("the authority of reason") is diminished or non-existent. Rigid obedience to authority becomes embedded within the culture because there is no alternative basis on which to make decisions; no-one wants to be held responsible, preferring instead to rely on the processes set in place by hierarchies of authority.

Since the asylums were physically separate from other hospitals and medical schools, the people running asylums would have had little up-to-date education in medical science of the day, let alone education in the more robust physical sciences. They would then have little idea of what a real explanation consists of. Then, due to fundamental lack of either understanding or education, no prior assumptions can be taken as given; and as a result, new "treatments" might be advocated on the basis of hunch with scant scientific reasoning.

All around staff saw profound suffering. This, in combination with underlying (if suppressed) fear might lead staff to deny the facts of suffering, to adopt a false sense of optimism, and to inflate the sense of their own role as members of healing professions. Abandonment of prior assumptions was then easily extended to the abandoning of assumptions about acceptable ethical principles. Staff might conclude that extreme forms of treatment were justified because they could not be much worse than was already present.

A culture where the harsh realities around them were denied, and the physical isolation of the asylums, may have led to deceptive, secretive and sometimes perfidious styles of communication when outsiders made enquiries about what was going on. Patronising attitudes might be adopted, again hiding knowledge from public gaze, about which there arguably should have been more openness. Lastly, in terms of recruitment of staff, the great vulnerability of inmates might be a "draw-card", attracting not only staff with the very best

of motives, but also those with the very worst – those who wanted to exert power, even to produce further torment, for those inmates.

Most fundamental to the above sequence of influences is *lack of understanding*. This is why fundamental research into the root causes of mental illness continues to be important, regardless of hopes that such research might lead to more effective and rational treatment.

Steps in unravelling the culture of hopelessness. The intergenerational process of exorcising mental health services from the ghosts of the asylum era has already been running for fifty years, and it still has a long way to run. However, a number of steps can be identified. We are now a hundred years removed from the time when a *defining* feature for *dementia praecox* was the inevitability of a bad outcome, and when *un-understandability*, was a criterion for distinguishing neurosis from psychosis. Few professionals would now regard schizophrenia as a form of dementia (although many do not yet recognise the full intelligence which people with this diagnosis may have). Admittedly, the general public does not yet fully grasp these advances, and this revelation may yet take many decades to reach its full fruition. Nevertheless, effective therapies both biological and psychosocial are now available for the most serious forms of mental illness, and there is increasing understanding of the need to combine the two (and how to do it). This in turn has led to improved understanding of the psychology and experiential impact of serious mental illness. The assumption that psychotic patients are *un-understandable* has gradually waned. There is now no need to separate (as Jaspers did) understanding in a scientific, and in a human relational sense. Knowledge of scientific findings about groups of patients, combined with steady improvement in clinical and communication skills means that both scientific and empathic understanding have improved together. Scientific understanding does not now mean adopting a faceless “objective” approach to patients. Further impetus has been given to the cultural change now in progress by pressure from community groups, initially those of caregivers, but more recently by the consumers themselves; and their efforts are supported by the increasing emphasis placed on human rights and concepts of medical ethics. With all these steps forward, it is perhaps the time also to look backwards, to reflect on the journey now under way, so that we understand where we have come from, where we are going to, and what we can learn from history.

Apology versus Acknowledgment? When an individual apologises for something, he or she usually knows what they are apologising for. When an enduring organization or society is called on to make an apology, initially no-one may know very well what is the real source of grievance. To unravel this, sometimes in the face of deliberate attempts at concealment, may take considerable effort in historical research. In the end the simple words “I am sorry” coming from official sources (that is from someone representing the organization) are largely irrelevant, little more than a trivial formality. What is needed however is *public acknowledgment*, and *public acceptance* of what happened, this being much more important than an explicit and formal apology. To *know in detail* what went wrong in the past, and to publicly acknowledge it, is the biggest step to reconciliation with the past, and the strongest safeguard against its being repeated.

Who needs to give public acknowledgment to the abuses within the asylums? I hear from diverse sources that most psychiatrists were not malign in their intent at the time of the abuses documented above, but were trying to do their best, often on the basis of poor understanding, limited resources, and in the face of public misunderstanding and suspicion. I accept these assurances, and have to admire the fact that psychiatrists *did* continue to practice, when at some level they may have known that they were often doing as much harm as good. How we moved from the utter chaos with which pioneers like Pinel had to contend, to where we are today, is to me, nothing short of miraculous.

The same is likely to be true in the psychiatric nursing profession, as Anthony Weare maintained: Most psychiatric nurses were not malign in intent. I also hear from diverse sources (psychiatrists and ex-patients, as also stated by Anthony Weare) that the atmosphere in each ward depended very much on the manner and professional standards of the person in charge of that ward – the charge nurse.

Most of the events and practices documented here occurred some decades ago, and many of those who practiced at the time, psychiatrists or nurses, are either no longer alive, or are now quite old. There is, in my view, no point in attributing personal liability to anyone practicing at that time, unless they are clearly *criminally* liable. Some former asylum inmates may reject this conciliatory approach. I respect their viewpoint, and admit that I am protected from such intense feelings, because I never spent long as an in-patient in a psychiatric facility. However I do not believe that retribution is the most pressing need, if we are to resolve the anger from the past. This only stokes the fires of further anger and grievance. It does little to spread public confidence in the more robust services now being developed, nor does it assist reconciliation and healing. To press for personal liability, justice and retribution will make those who are accused defensive, and less likely to reveal what they know. This will make it more difficult for the truth to be made public. If we have to choose between truth and justice, truth has to be the priority, in my opinion. That way we look to future improvement; to press for justice, is to look backwards. These arguments undoubtedly lay behind the form taken by the Truth and Reconciliation Commission, in post-apartheid South Africa.

However, I do believe that some sort of professional response is needed from three groups, as cornerstones on which can be built public trust in mental health services of the future: *First*, since the abuses occurred in state-run institutions, the governments of today (embodying the New Zealand State, as an enduring political entity) need to acknowledge publicly what happened. *Second*, I believe that the nursing profession should be involved in the same process, should investigate its own role in abuses, and should put on public record its acknowledgment of what happened on its watch. *Third*, I think of the profession of psychiatry. Most psychiatrists were not in any way culpable, but psychiatrists *were* involved, in at least two ways. (i) I presume that people did not get sent to these asylums without a signature from a trained psychiatrist. (There may be some exceptions to this when people were “put away” with less of a formal procedure, for instance if they were seen as troublemakers.) (ii) The statutory authority for running asylums lay not only with the government of the day, but also with leaders of the psychiatric profession at the time. Did those leaders of the profession know what was happening? I do not know, but if they did not know, I believe they should have known; yet several persons in the evidence cited above mention that psychiatrists were notable by their near-complete absence from the asylums. In either case I can only conclude that there was a major element of connivance – of turning a blind eye to what, at some level those leaders must have been aware of²¹. In the end, there might have developed a whole “culture of connivance” by those holding ultimate responsibility. As Shakespeare put it in *Macbeth*:

*The eye wink at the hand, yet let that be
Which the eye fears, when it is done, to see.*

²¹ There is evidence of what appears to be connivance by RANZCP, following comments made about events at Chelmsford by Sir Martin Roth in January 1981, and a subsequent letter sent to the college by Dr John Sydney Smith (see reports in *Sydney Morning Herald* (“Chelmsford ‘Deep Sleep Therapy’”: 30/7/88-6/8/88).

Alternatively there *was* no connivance: The leaders might have been well aware of what was happening, but were anxious to keep it from public knowledge. They were, in effect, the “bomb disposal squad” with respect to policies set in place decades (even centuries) earlier; and an upsurge of public anxiety would not help their conscientious best efforts to defuse that bomb safely. Overall, I do believe that some response is needed from the current professional bodies representing psychiatry, these being the continuation of organizations under whose watch the abuses occurred. However, before this can occur those organizations need to be fully aware of the degree of their own institutional involvement and responsibility.

Conclusions and Recommendations

The abuses in asylums of New Zealand in former times are *not* aberrations: They are expressions of a disturbing aspect of human nature itself, in any society. This hard fact is probably the most important lesson we can take from the history of mental health services; and unless we have fully assimilated this into our thinking, we have not truly come to terms with that history. This is not to say that everyone has the potential to perpetrate such abuses, but in any society there is a proportion of people who are so capable. Thus, as noted earlier, abuses in asylums are not just history. Every society from time to time faces the same issues. To be specific, there are - in the here and now - areas of mental health systems to which many of us turn a blind eye. I hear regular reports that for the most seriously ill patients, conditions have changed little compared with former times; and most of us know little (and want to know little) about the plight of seriously mentally ill persons in prison populations. There is also an approaching and much larger challenge, where it can be clearly foreseen that similar issues will arise: As Western populations age, there will be the need to care of vast numbers of mentally-disabled elderly people. Are we ready for *this* challenge? Every society has to fight for civilised values on the basis of its own experiences, and how the issues are presented to *them*. There is no final solution to these issues; but knowledge of history *can* help. What systems need to be put in place and firmly established, to protect civilised values in mental health care?

A Permanent Process Within RANZCP, Equivalent to the Confidential Forum in New Zealand? In my introduction to the Hobart symposium, I spoke of the need for an extended process of discourse amongst the different stakeholders, working in relatively small groups in each locality, perhaps going over the same ground a number of times, so that consensus may gradually emerge, and true healing can take place for all participants. As in the New Zealand process, most of that discourse *should* be confidential. This is partly because people who have been traumatised within mental health systems are likely to speak more freely if they speak in confidence. Moreover, in telling stories it would be impossible to avoid personally identifying individual staff members; but since the process is seen in a political rather than a legal sense, personal accusations within these stories is not the point; and being confidential, such hearings would avoid any suggestion of personalised vendettas. I believe the college should be open to this, so that it knows the history, including its own history, which has created current public attitudes to psychiatry.

This suggestion is offered as a response to abuses *of the past*. However, since the potential for abuse within mental health systems is a permanent and on-going feature of the mental health professions, against which their leaders should always be seek preventative measures, it seems logical to suggest that such confidential forums should have some sort of permanent status within college structures. Within New Zealand, an on-going process does now already exist, as a spin-off from the Confidential Hearings from 2005-2007. As

RANZCP reaches out to the communities it serves, this would be an enduring symbol of on-going concern to identify and minimise abuse within mental health systems. This should encompass private as well as public services, especially in Australia, where much psychiatry is in the private sector.

The Ethic of Transparency. Documented abuses in the asylums grew in a culture of secrecy; they would hardly have persisted unchecked had they had to face the light of day. Therefore promotion of an ethic of transparency is one of the strongest safeguards against such abuse reappearing. However, the extent of transparency needs to be carefully judged. The transparency of Bedlam in Jonathan Swifts' day was little avail in bringing humanity to such institutions. The realities of serious mental illness are quite disturbing for lay persons, as are many aspects of medicine generally; the most severely disturbed patients are the ones about whom secrecy is most likely to prevail. However, transparency *should* nevertheless mean close involvement of *informed* community personnel, representing the real stakeholders of mental health services. Such personnel include some positions which already exist, such as the District Inspectors, who supervise implementation of Mental Health Acts and hospital or prison chaplains (probably the only group who, as independent observers, get to know patients at a genuinely personal level). The newly emerging role of community representatives within RANZCP provides another source of independent scrutiny of mental health services. The principle of "freedom of information" now applies in many areas in many jurisdictions, and something like this is growing within health systems. For instance, patients now often have a legal right to see their medical records, and I hear from the UK that there are moves afoot which may lead to medical staff and patients working together as collaborators in writing the patient's medical records. Of course medical confidentiality requires that personal details not to be shared indiscriminately. Nevertheless there should be openness within mental health systems to give answers to more generic questions. Two examples in my own recent experience come to mind: (i) For forensic patients receiving antipsychotic drugs, what is the usual dose, and range of doses? (ii) Under what circumstances in modern acute mental health services are strait jackets still used? When questions such as these are asked, it should not be the case that sincere enquiries are met with a "stone-wall" approach. The public has a right to have such questions answered. If answers are not forthcoming to discrete confidential enquiries, then enquiries should then be made in public.

Authority and its limits within medical culture. Arguments have already been presented in favour of people who bear ultimate authority for medical decisions having a degree of protection, given the uncertainties and risks inherent in many of those decisions. However, this does not mean that the organizational culture should become rigidly hierarchical, with unquestioning reliance on the unaccountable authority of people at the top of the profession, beneath which is an unchallengeable chain of command, so that the only defence of questionable practice is likely to be "I was following orders". Respect for the superior experience of those who have been in the profession longest should not preclude question and debate over contentious issues; nor should it lead to a culture of secrecy and, eventually, of connivance. Respect for superior experience should not preclude openness to continual rigorous scrutiny by independent bodies. Open debate should be possible, at least amongst peers, including lay people with adequate background knowledge, who are in a position to see the tension between opposing pressures. The cult of authority should not prevent accurate recording of the debates and the bases for decisions, so that scrutiny in the future can identify the tensions, and the trail of accountability. The attempt by the professionals to stay objective should not merge into deliberately dehumanising and

depersonalizing attitudes to patients and their care. Acceptance that there sometimes be harmful side effects of treatment should not merge into acceptance of deliberate cruelty.

Defining a charter for whistleblowers. Most large organizations, whether health services or nation states are reluctant to admit mistakes from the past, and may become defensive when current malpractice is exposed. Destroying critical documents is common practice in such situations. Organizations do not like, and have various means of gagging would-be whistle blowers, or victimizing those who *do* speak out. Admittedly, whistle-blowers may sometimes be on shaky ground: They *may* lack the experience to balance opposing pressures; and just because they are taking a personal risk by speaking out does not mean that they are necessarily right. Nevertheless the role of whistleblowers is increasingly recognised in legislation, precisely to increase the accountability of government and other powerful agencies. In the UK National Health Service, a recently proposed “Charter for Whistleblowers²²” included a contractual right for staff to speak out about malpractice without fear of dismissal or disciplinary action, and an independent watchdog to which staff could turn if their concerns were not addressed. In addition gagging orders in employment contracts would be forbidden. This would mean that health service staff who are aware of malpractice or abuse, and yet fear that they may lose their jobs if they blow the whistle, may yet be assured that, if they do resign and then speak out, no further measures could be taken against them. If there is one area of health care where such provisions are *most* needed it is in the mental health field. The RANZCP should give its backing to strengthening such legislation (which is not yet uniform and comprehensive across the two countries in its domain).

Redefining the relation between the psychiatric profession and the agencies of the nation state. Part of the defence of whistle blowers involves re-defining the relation between the psychiatric profession and the governmental and other statutory authorities in whose jurisdiction they function. Medical professionals mainly see themselves as agents of their patients, but in all specialities there are also occasions where they are to some degree agents of the nation state. In the past, in psychiatry the balance between these two roles has been different from that in other specialities, staff acting more as agents of state control, and less as agents of their patients. This is probably one reason why psychiatrists in the past have often been unapproachable: They *were* responsible, but to state authorities, rather than to patients or their families. With the shifting focus of the profession described earlier in this essay, the relation between the psychiatric profession and organs of the nation state needs to be re-thought. It is beyond my agenda to suggest details of such re-shaping, but it should be a matter of concern to current leaders of the profession. One point can be made however: Since a professional body such as RANZCP is more permanent than any government-of-the-day, it should feel no obligation to bend its practice to suit the government-of-the-day, and should know how to stand firm in the face of government pressure.

*Will There be **Any** Continuing Need for Asylum-type Care?* Nowadays there is little need for the “culture of hopelessness” which prevailed in asylums of the past. Moreover, it is clear that, for a mentally ill person to be in a hospital ward surrounded by others with a diverse range of psychiatric problems and behavioural disturbances, is intrinsically bad, and an abrogation of the professional duty to provide optimal care. For these two reasons, it is sincerely hoped that the large asylums *are* things of the past, not to be reinvented at some

22 Oliver Wright: “Coalition considers ‘charter for NHS whistleblowers’”. *Independent*, 13.10. 2010.

future date. Nevertheless it is accepted that there will remain very difficult patients, at least in forensic settings, where institutional care, usually in secure facilities, will still be needed.

Postlude: In Memory:- Gerald Cessford

I finish this essay with another poem, one which I have inherited from a friend, now no longer living. I got to know him in my early days in New Zealand, a well-educated, highly-intelligent and quite scholarly young man, fluent in German, with a degree from Otago. Even then, he was outside the mainstream of life, because of an illness – presumably a psychotic illness - although I never knew much about this. I also knew his mother, one of the bitterly aggrieved parents I listened to at the time. I know nothing in detail of the source of her anguish; but I presume it was to do with the treatment her son received in a mental hospital, before I arrived in New Zealand. I remember Gerald's cheerful breezy greeting, "Giddyay, you old ratbag!", despite already some degree of impairment. Much later I came to know him better, when he was severely impaired, massively overweight, living in a single room, curtains usually drawn, and in bed much of the day. I lent him my copy of George Elliot's *Middlemarch*, and over the next eighteen months, carefully he read it through. I have no doubt he enjoyed it and remarked on the formidable intelligence of its author (real name: Mary Ann Evans). He died around the year 2004, while I was out of the country, so I did not attend his funeral. A few years later, I was at his mother's funeral. I do not know when the poem I reproduce below was written, but from its content, I guess that it was at a time, in the mid-1970s, when he had already had profound traumas in his life, and could foresee the ordeal which the rest of his life would become.

Prayer

Gerald Cessford

Father, I approach You
at daybreak
To ask your guidance in the peace
Of early morning whilst in uncertainty.
May Your words give wisdom to those
Coming to You in need and humbly
Seeking Your help.

Father, I approach You
at daybreak
In time of transition to light to pray
For endurance through all that your will
And Your oppressors may prepare,
That we might forgive those that
Transgress against us.

Father, I approach You
at daybreak
In prayer in a lonely, barren place
To take courage from Jesus' suffering

In the face of darkness and enmity.
In your name may we also find that
Kind of strength

Father, I approach You
at daybreak
Mindful of those who have stood by You
Never knowing whence Your light might come.
We need Your help to forgive those whose
Hearts are with carelessness and cruelty
To their fellowman

Father, I approach You
at daybreak
And pray that Your grace be given
Those striving for a way out of darkness
In times of bitter news and betrayal.
That we might live up to Your name,
Grant us this day.

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