Queensland Health

Wolston Park Hospital Review

Report into experiences of treatment and care at Wolston Park Hospital: 1950 to 2000

Professor Robert Bland AM

Queensland Government

Report into experiences of treatment and care at Wolston Park Hospital: 1950 to 2000 | Wolston Park Hospital Review

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Executive summary

The Wolston Park Hospital Review (the Review) was commissioned by Queensland Health and led independently by Professor Robert Bland AM. The purpose of the Review was to enable former patients, residents and their families and carers to describe their experiences of treatment and care at the former Wolston Park Hospital between 1950 and 2000 (inclusive). The *Report into experiences of treatment and care at Wolston Park Hospital: 1950 to 2000* (the Report) summarises the information provided to the Review, identifies emerging themes related to treatment, systemic issues and experiences in Wolston Park Hospital and recommends the Report be made public.

This project operated under the guidance of Terms of Reference developed when the project commenced under the leadership of Professor Robert Bland AM. The Review acknowledges prior work undertaken by the Queensland Mental Health Commission in conducting consultation with former patients and residents of Wolston Park Hospital, and their families and carers, to inform these Terms.

Terms of reference

As per the Terms of Reference, the Review:

- Heard the stories of former patients and residents of Wolston Park Hospital and their family members or carers about experiences between the years 1950-2000 (the Review Period).
- Provided a thematic analysis of collected content to identify systemic issues, emerging themes and experiences of Wolston Park Hospital.
- Did not determine the truth or validity of participants' experiences, determine liability, recommend or facilitate financial compensation, judge participants or anyone mentioned by a participant or reach a definitive conclusion about what might or might not have happened.
- Did not provide direct clinical assessments or care to participants but did facilitate community-led support for participants when requested.

Consultation

The Review enabled participants to share their stories, often unspoken before this time, in a confidential and trauma-informed setting to a person who would actively listen and hear without agenda or judgement. While the primary focus was on former patients and residents and their families or carers, some former staff and external experts were interviewed to provide context, background and understanding of the patient, family and carer experience during the Review Period. The Review was conducted in a trauma-informed manner to minimise the risk that the Review process and outcomes could inflict harm or negatively impact the wellbeing of the participants. The key principles that shaped the Review process were:

- The centrality of lived experience of mental illness and care as a focus for the Review.
- The importance of listening and hearing.
- The Review: For us or for them?
- That was then, this is now.
- The illness or the treatment?

Consultation consisted of one-on-one interviews with participants over a 10-week schedule. Initially, 83 members of the public registered interest in the process, and 66 continued to interview. Some of those who registered interest removed themselves from the process after considering their wellbeing or determining that the process would not be of value to them. Some were only interested in updates on the progress of the Review. Some were deemed out of scope due their lived experience being associated with a different institution or time frame. A number of those who initially registered were only interested in accessing family member records from Wolston Park Hospital and were provided with information about how to do this under the *Right to Information Act 2009 (Qld)*.

Interviews were conducted with 14 former patients, 25 family members, 18 former staff and nine participants on the periphery of the hospital, such as a local priest and Brisbane historians. The majority of interviews, 44 in total, were conducted in South-East Queensland (66 per cent) while nine required travel across Queensland and interstate (14 per cent). To support participation from participants living overseas or for those who preferred an online interview for various reasons, 13 of interviews occurred virtually (20 per cent), including four international participants.

Thematic analysis

The themes identified within this Review pertain to the historical period of 1950-2000 and are relevant only to experiences within Wolston Park Hospital. As an historical report, the following themes are not intended to reflect current mental health or human services policy, service provision or experience.

The interviews produced over 2,000 pages of transcript which were analysed thematically and summarised under the following headings:

- **Culture and governance:** Participants of the Review reported on a complex governance structure in the hospital which allowed problems in patient care to arise and persist.
- **Medication, electroconvulsive therapy (ECT) and treatment:** Participants reported on negative experiences with medication and treatments.
- **Sexual and physical violence:** Some participants reported sexual and physical violence, particularly in Osler House and Pearce House.
- **Families:** Participants reported on the impact of mental illness, hospitalisation and treatments on family welfare. Families were identified as a protective force which shaped patient experience within Wolston Park Hospital.
- **Supportive individuals made a difference:** Many participants identified individuals who had made a positive difference on their experience of hospital care.
- **Positive levers for change:** Participants described the changes in treatment and governance that impacted the care received.

Emerging themes identified from the stories shared with the Review include:

- The impact and intersection between vulnerability and power dynamics between the patients, some of the staff and the system in which they interacted.
- Trauma can be enduring but there is also power in the opportunity to heal.
- The systemic issues present during the Review Period which influenced the operations of Wolston Park Hospital and the experiences of patients, families and carers.
- The lessons for policy, practice and teaching.
- Sometimes systems fail but families might get it right.

Recommendations

The real value of the Review was in providing an opportunity for former patients and residents of Wolston Park Hospital, and their families and carers, to share their experiences and for their voices to be heard by a person in authority. An important part of concluding the Review process is that the voices of former patients and residents, and their families and carers, should also be heard by the broader public. Participants provided information with a clear desire to have their stories made public. Wolston Park Hospital closed twenty-five years ago, a sufficient time for an historical perspective to overtake any personal sensitivities that would suggest the lived experience of participants should not be openly reported. Some participants expressed a strong preference for their names to be included where they wrote directly of their or their loved one's experience (*Appendix 4*). Withholding their names was, for some, a further extension of their sense of being silenced by the Queensland Government. Such publication was not possible given the Terms of Reference,

which strictly protects the privacy of participants and hve regard to privacy considerations relevant to non-participants.

The Review recommends that:

1.	The Report be published in its entirety.
2.	Queensland Health allows the publication of the names of participants in *Appendix 4 – Participant's Stories in Their Own Voices*, where this has been specifically requested by the participants.

Preface

The Review was established to enable patients and residents of Wolston Park Hospital, and their families and carers, to speak to the Queensland Government about their experiences of treatment and care at the former Wolston Park Hospital between 1950 and 2000. I was appointed as the Independent Lead Reviewer for the project.

The Review enabled participants to share their stories in a confidential and trauma-informed setting to a person who would listen and hear without an agenda or judgement.

The Review was not established to determine the truth or any liability. It was established to allow the Australians who feel forgotten or abandoned by the system to speak their truths. They shared their stories with me with confidence and candour to establish a record of their lived experience which would be shared with those in positions of power and decision-making. Their participation was selfless and frequently motivated by a desire to see change in the mental health and institutional systems which caused them harm.

This Report contains an overview of what was shared via thematic analysis and identifies emerging themes related to the treatment and systemic issues present at Wolston Park Hospital during the Review Period. It highlights the relationships between the vulnerable and those in power and demonstrates the value of listening and hearing the lived experience of the people the Government serves. The Review was afforded the opportunity to make recommendations for Queensland Health, including whether this Report should be made public, which I full-heartedly recommend.

There are two audiences for the Report. In the first instance it is a report to the Director-General, Queensland Health, but a second audience are the participants who shared their stories with me. Many of those participants insisted they wanted to speak for their friends who for various reasons, could not speak for themselves. I have tried as much as possible to speak clearly and bravely, as the participants would want me to speak.

There is value to be gained and lessons to be learned from undertaking such an exercise. Value exists in empowering people to speak and be listened to. By hearing and listening to the stories of people's experience of policy or clinical models, the system can learn how to better treat their illnesses and to minimise the opportunities for abuses and trauma.

Professor Robert Bland AM

Content disclaimer

This Report includes descriptions of alleged physical and sexual violence and human rights abuses as told by the participants who spoke to the Review. It is acknowledged that the content may be distressing.

The reporting of this content is not an indictment or conclusion that the events occurred as described or that there is liability to be found in the actions. Rather it provides an account of the reported experiences of those who lived, were treated, and who had family members and loved ones at Wolston Park Hospital during the Review Period.

Support services

Reading this Report may bring up challenging thoughts and feelings.

In an emergency call 000 or go to your local hospital emergency department.

- 1300 MH CALL – 1300 642 255
- Blue Knot Foundation – 1300 657 380
- Lifeline Australia – 13 11 14
- Suicide Call Back Service – 1300 659 467
- Beyond Blue – 1300 22 46 36
- MensLine Australia – 1300 78 99 78
- Kids Helpline – 1800 55 1800
- 1800RESPECT – 1800 737 732
- 13YARN – 13 92 76 (service for Aboriginal and Torres Strait Islander people)
- Arafmi – 1300 554 660

For people living with the impacts of institutional childhood abuse in Queensland, please consider contacting Lotus Support Services, Micah Projects on (07) 3347 8500 to access support, resources and community.

Acknowledgements

The Review acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia. We pay our respects to Elders past and present as the Traditional and Cultural Custodians of the land, water and skies of where we work. We also acknowledge the Traditional Owners and Cultural Custodian of the lands around Wolston Park Hospital – the Jagera, Yuggera and Ugarapul People – and the First Nations patients who lived there.

The Review would like to acknowledge the voices of all who contributed to this Review and shared their experiences. The Review appreciates the courage of participants in sharing their stories and the ongoing impact of experiences in Wolston Park Hospital and their contribution to improve healthcare services in Queensland. The Review also wishes to acknowledge the brave individuals who petitioned the Queensland Government for this Review and thank them for their tenacity and drive to see their experiences shared with Queensland.

Thank you to the following individuals who provided individual feedback throughout the Review:

- Ms Irene Clelland, Chief Executive Officer, Arafmi.
- Dr Frances Dark, Clinical Director Rehab, Metro South Hospital and Health Service.
- Mr Ivan Frkovic, Queensland Mental Health Commissioner.
- Mr Jorgen Gullestrup, former Chief Executive Officer, Mental Health Lived Experience Peak Queensland.
- Ms Amanda Leonard, Senior Director Strategy and Policy, First Nations Health Office, Queensland Health.
- Professor Donna McAuliffe, Griffith University, Queensland.
- Ms Rebecca Reynolds, Chief Executive Officer, Queensland Council for LGBTI Health.

The Review acknowledges the work undertaken by the Queensland Mental Health Commission prior to Queensland Health commissioning the project. The Review thanks the Commission staff who worked with prospective participants to establish the scope of the Review and are grateful for their grace and support in transitioning the project.

The Review would also like to thank Queensland Health, including Director-General, Dr David Rosengren, and the Minister for Health and Ambulance Services, the Honourable Tim Nicholls MP, for their support in undertaking this process.

Review Team

Lead Reviewer	Professor Robert Bland AM
Assistant Reviewer	Ms Bronwyn Charles
Project Sponsor	Ms Peta Bryant, Deputy Director-General, System Policy and Planning Division
Program Manager	Mr Brody Cutting, Manager Strategic Projects, System Policy and Planning Division
Contributors	Mr Damien Searle, Executive Director, Reform Office Ms Sally Nahak, Advanced Specialist Clinical Support Coordinator, Reform Office Ms Elizabeth Jacques, Senior Project Officer, Reform Office Ms Lou Burke, Project Support Officer, System Policy and Planning Division Ms Felicity Hishon, Project Support Officer, Reform Office Dr Yvonne Darlington, Independent Contributor

Glossary of terms

The following table provides a description of terms used throughout this document and within quotes from participants of the Review, including medications used and wards of Wolston Park Hospital.

Term	Description
Key terms	
Lead Reviewer	Refers to Professor Robert Bland AM in his capacity as the Lead Reviewer, Wolston Park Hospital Review.
Participants	Refers to the people who participated in the Wolston Park Hospital Review by providing oral or written statements.
The Report	Refers to this document, the *Report into experiences of treatment and care at Wolston Park Hospital: 1950 to 2000* (the Report).
The Review	Refers to the Wolston Park Hospital Review (the Review) as a project, process and Team.
The Review Period	1950 to 2000 inclusive.
Wolston Park Hospital	Wolston Park Hospital, the subject of this Review, was a Queensland State mental health facility located in Wacol which operated for 135 years under various names. Within participant quotes, the facility is referred to alternatively as *Goodna, The Park* or *Wolston Park*.
Treatments and medications	
ECT	Electroconvulsive Therapy (ECT) is a medical treatment that rapidly relieves symptoms of severe psychiatric disorders. ECT involves the delivery of a small, pulsed electrical current to the brain sufficient to induce a seizure for therapeutic purposes. ECT is performed whilst the person undergoing treatment is under general anaesthesia.
Insulin coma therapy	Insulin coma therapy, or insulin shock therapy, is an historical (circa 1930s-1950s) psychiatric treatment used to treat severe mental illness by delivering large doses of insulin to patients to induce a coma. The practice was phased out of mental health treatment plans following the introduction of antipsychotic medications beginning in the 1950s.
PRN	PRN, or *pro ne nata* (Latin for *'in the circumstances'*), medications are medications that are administered to manage symptoms as determined by an individual's assessment of a situation as opposed to a prescribed schedule. This does not typically mean that a medication is administered to exceed a prescribed daily amount, but rather that it is to be administered only if needed. The administration of PRN medications is required to be monitored, recorded and reviewed by the treating team to ensure that it remains appropriate.
Psychotropic medications (See description for specific medications)	Multiple psychotropic medications are referenced by either generic or trade names throughout this report. They include the following, with generic medication name first with the trade names in brackets and capitals: • haloperidol, • chlorpromazine (Largactil or Thorazine), • paraldehyde,

	• promazine. Psychotropic medications such as these medications have been used in the treatment of mental illnesses. Promazine and paraldehyde have not been used routinely since the 1970s. Since the advent of newer antipsychotic medications in the late 1990s, the use of chlorpromazine and haloperidol has become less common. They are now used only rarely and in particular situations, including when medications with lower side-effect burden are not effective.
Restraint	Restraint refers to practices used as an intervention considered justifiable to protect the safety of patients and/or staff. It may refer to: • physical restraints (e.g. limitations of movement such as holding a patient by the body), • mechanical restraints (e.g. limitations of mobility such as a restraining a patient to a bed or chair), • chemical restraints (e.g. the use of PRN psychotropic medications. Note that the use of medications within historical and current mental health services is considered as treatment within an acute scenario as opposed to a mechanism of restraint), or • environmental restraints (e.g. locked wards, isolation rooms or restrictions of movement between areas).
Seclusion	Seclusion refers to the practice of isolating a patient in a room or area which they cannot leave. It is intended to be used in extreme circumstances only as a measure to prevent serious harm to the patient or others.
Wards of Wolston Park Hospital *Note, the following is not an exhaustive list of wards and functions within Wolston Park Hospital. Rather it provides a summary of wards named in this report, including in participants quotes.*	
Barrett Centre	Opened in 1979, the Barrett Centre was a 160-bed unit to treat acute admissions and shorter-stay patients as opposed to longer-stay patients in other wards of Wolston Park Hospital. In 2000, the Barrett Centre had been decommissioned by the time of the broader Wolston Park Hospital closure and many of its structures were later demolished (excluding the Barrett Adolescent Centre).
Barrett Adolescent Centre	Opened in 1983, the Barrett Adolescent Centre was within the complex of the broader Barrett Centre to treat adolescent long stay and day patients aged between13 and 18 years old. In 2014, the Barrett Adolescent Centre was closed.
Ellerton House	Opened in the 1960s, Ellerton House was described to the Review as housing psychogeriatric and dementia patients. It was decommissioned by the time of the broader Wolston Park Hospital closure in 2000 and later demolished.
McDonnell House	Built in 1915, McDonnell House was a general ward originally used to house male patients. In 1987, the Clinical Studies Unit of Wolston Park Hospital was established as a 26-bed inpatient unit within McDonnell House. The Clinical Studies Unit was relocated on site and by the late 1990s had evolved into the Queensland Centre for Mental Health Research. In 1991, the ward was closed, and the building heritage listed in 1992. The building is currently owned by the Queensland Police Service and is not in use.
Osler House	Osler House was a secure (locked) ward for female patients used to house both forensic patients and women from the broader hospital who were deemed to require environmental restraint.

	In 1991, Osler House was closed, and in 1992 the building was heritage listed. The building is currently owned by the Queensland Police Service and is not in use.
Pearce House	Pearce House was a secure (locked) ward for male patients used to house both forensic patients and men from the broader hospital who were deemed to require environmental restraint. In 1991, Pearce House was closed, and in 1992 the building was heritage listed. The building is currently owned by the Queensland Police Service and is not in use.
Other	
Clinical Studies Unit	In 1987, the Clinical Studies Unit of Wolston Park Hospital was established as a pharmacology research unit via 26 inpatients beds within McDonnell House. The Clinical Studies Unit was relocated following the closure of McDonnell House in 1991 and by the late 1990s had evolved into the Queensland Centre for Mental Health Research on the former site of Wolston Park Hospital.
Nurses Training School, **Wolston Park Hospital**	In the 1960s, the Nurses Training School, Wolston Park Hospital was established as an on-site education facility for mental health nurses. Within participant quotes, the Nurses Training School is referred to alternatively as *the Nursing School, the School of Nursing* or *the School*.
Patient's Friend	The Patient's Friend refers to a position held within Wolston Park Hospital which represented the Office of the Patient's Friend. The Office of the Patient's Friend and associated position was established in 1977 to serve as an advocacy role in the individual rights of patients in their treatment plans and to provide protections from abuse and unnecessary controls.
Project 300	Beginning in 1995, Project 300 was a Queensland Government initiative which aimed to prepare and discharge some 300 patients from Queensland mental health hospitals to community-based accommodation. Given Wolston Park Hospital was the largest mental health hospital in Queensland at the time, Project 300 had a significant impact on its operations and purpose in the mid-late 1990s.
Red Book	The 'Red Book', also known as the *Handbook for Mental Nurses*, published by the British Medico-Psychological Association since 1885 (Finnane 2008), was an historical manual, bound in red cloth, of standardised clinical activities that covered basic mental health nursing care. The Red Book was used as a part of training for mental health nurses at Wolston Park Hospital up until the 1960s.
Wilson Youth Hospital	Opened in 1961, the Wilson Youth Hospital was a state-Government remand centre for children and young people under deemed difficult to manage in other home or institutional settings, children under detention, or those who were orphaned or homeless and unable to be supported in out of home care. Wilson Youth Hospital was renamed to Sir Leslie Wilson Youth Detention Centre in 1983. The facility was eventually closed in 2001.

1 Introduction

The Wolston Park Hospital Review (the Review) was commissioned by Queensland Health and led independently by Professor Robert Bland AM. The purpose of the Review was to enable patients and residents, and their families and carers, to describe their experiences of treatment and care at the former Wolston Park Hospital between 1950 and 2000 (inclusive). The *Report into experiences of treatment and care at Wolston Park Hospital: 1950 to 2000* (the Report) summarises the information provided to the Review, identifies emerging themes related to treatment, systemic issues and experiences in Wolston Park Hospital and recommends the Report be made public.

This project operated under the guidance of Terms of Reference developed when the project commenced under the leadership of Professor Robert Bland AM. The Review acknowledges prior work undertaken by the Queensland Mental Health Commission in conducting consultation with former patients and residents of Wolston Park Hospital, and their families and carers, to inform these Terms.

1.1 Background for establishment of the Review

In August of 2024, a group of people who had a lived experience of the former Wolston Park Hospital as either patients or family met with the former Minister for Health, Ambulance Services and Mental Health Services and Minister for Women (the former Minister) to call for a Truth Commission into the treatment of patients at the Hospital. The former Minister initially directed the Queensland Mental Health Commissioner to investigate health services provided at Wolston Park Hospital. Due to the historical nature of the experiences and that Wolston Park Hospital is not an active mental health facility, the former Government decided to transfer the investigation under the auspice of Queensland Health to be undertaken as an independent process of storytelling with volunteer participants.

Following the change of Government in late 2024, the Director-General of Queensland Health and the Minister for Health and Ambulance Services determined to continue the process to enable people to share their experiences of Wolston Park Hospital.

1.2 Appointment of Professor Robert Bland AM, Lead Reviewer

Professor Robert Bland AM was appointed as Lead Reviewer in October 2024 following the recommendation of the Queensland Mental Health Commissioner, Mr Ivan Frkovic. Professor Bland has extensive experience in the national mental health field, having worked over 50 years as a clinical social worker, educator and academic.

Professor Bland was chosen to lead this Review based on his professional and personal qualities as a compassionate clinician who values the lived experience of people living with mental health conditions, and their families. As Lead Reviewer, he led this process in a trauma-informed manner and focused the energies of himself and the Review Team on providing a safe environment for participants to share their stories and, hopefully, to shine a light in the darker corners of institutional experiences as told by participants.

1.3 Process and reporting

The Review was supported within Queensland Health by the Deputy Director-General of System Policy and Planning Division, and a team within the division. The Lead Reviewer met weekly with the Deputy Director-General to keep them informed of the methodology, and progress and outcomes of the Review. The Lead Reviewer periodically reported to the Director-General on matters of direction and progress, though the Review was largely conducted at an arm's length from Queensland Health.

1.4 Structure and style of the Report

The Report provides a summary of information received from participants and the key themes that have been drawn from this, and recommends the Report be made public.

As the Lead Reviewer and Author of this Report, I (Professor Robert Bland AM) have occasionally written in the first person to provide my observations and reflections on what was shared, the emerging themes within the experiences of participants, and the implications of these themes within the current context. I do this to honour the deeply personal nature of the information shared with this Review, and the personal way in which it was received and heard.

The Report is separated into the following five chapters:

- **Background history of Wolston Park Hospital**, which contextualises the environment in which the stories of participants occurred and the analyses that follow.
- **Scope and Methodology**, which describes the approach to engaging with participants and hearing their stories, and how the Review bore the potential risk of re-traumatising participants who had carried decades worth of memories related to Wolston Park Hospital. This section summarises the trauma-informed approach applied by the Review to prioritise the safety of participants.
- **Underlying Principles that Shaped the Review**, which defines the values and principles which informed the approach to conducting this Review. The adherence to these principles gave the Review Team's work an integrity that was based on a deep respect for the experience of the participants who shared their stories.
- **Summary of Information Provided by Participants of the Review**, which carefully summarises the content from over 2,000 pages of interview transcripts and defines six identified categories relating to the experiences of participants.
- **Emerging Themes**, which draws thematic observations relating to the health services provided, systemic issues at play, and how the value of lived experiences and the stories told to the Review can provide lessons for policy, practice and teaching.
- **Recommendations**, which presents two recommendations relating to the publication of this Report.

There are also four Appendices attached to the Report. These include:

- A copy of the Terms of Reference for the Review (*Appendix 1*).
- A more detailed description of the trauma-informed approach used in the Review (*Appendix 2*).
- A publication record of research conducted at the Clinical Studies Unit of Wolston Park Hospital (*Appendix 3*).
- A compilation of individual stories from the participants of this Review (*Appendix 4*). All participants were invited to submit a short piece on any aspect of their experience that they wanted to share with the public. These submissions allow the participants to speak directly to the readers of this Report, and their voices are powerful.

2 Background history of Wolston Park Hospital

The site of what was Wolston Park Hospital in Wacol was initially settled in 1865 as the Woogaroo Lunatic Asylum, the first of its kind in the colony of Queensland. In the late nineteenth century, political and clinical policies and social guidelines promoted the separation of the mentally ill for both their own protection and the protection of the public. Before 1865, people in Queensland living with or classified as having a mental illness were housed in the Boggo Road Gaol (formerly Brisbane Gaol), Dutton Park. Woogaroo Lunatic Asylum underwent multiple name changes over the 135 years it was operational. During the Review Period (1950 to 2000), the facility at Wacol was known as:

- Brisbane Mental Hospital (up to 1963),
- Brisbane Special Hospital (up to 1969), and
- Wolston Park Hospital (up to its closure in 2000).

Over the Review Period, there were gradual policy and legislative changes which aimed to transition the treatment of mental illness from a model of custodial care towards patient-centred and community-based treatments.

Policy/ legislation	Details
Mental Hygiene Act 1938 (Qld)	From the onset of the Review Period, residency and treatment was influenced by the *Mental Hygiene Act 1938 (Qld)* which aimed to medicalise mental illness and required active treatment for people with a mental illness. Despite this, the *Mental Hygiene Act 1938 (Qld)* maintained the custodial and institutional model of nineteenth century asylums, with broad powers for involuntary detention and no legislated patient rights to be informed of or participate in their treatment plans, or to advocate for their own review or discharge.
The *Mental Health Act 1962 (Qld)*	The *Mental Health Act 1962 (Qld)* saw the commencement of government directions to shift psychiatric services into general hospitals, aiming to focus treatment outcomes on rehabilitation and limit the need for admissions in an isolated asylum setting.
Mental Health Act 1974 (Qld)	The *Mental Health Act 1974 (Qld)* shifted language describing people with a mental illness from 'inmate' to 'patient'. A subsequent amendment in 1983 saw the establishment of the Mental Health Tribunal to assess fitness for trial or detainment under involuntary orders. Although the *Mental Health Act 1974 (Qld)* aimed to modernise terminology and practice, it did not yet provide a statutory definition of mental illness (that was introduced later in the *Mental Health Act 2000 (Qld)* following the closure of Wolston Park Hospital), or fully provision institutions and treating teams to value patient consent in decision making about their own treatment and/or confinement.

Wolston Park Hospital served as a state-wide institution to provide longer-term psychiatric care and asylum to Queenslanders and was once the largest mental health hospital in Australia. Although other psychiatric hospitals existed for patients from regional and rural settings, Wolston Park Hospital accepted patients from across the state. At its peak population in 1956, Wolston Park Hospital housed 2,513 inpatients. From 1950 to 2000, the population of Wolston Park Hospital slowly dwindled as focus switched to treating people in community settings and de-medicalising mental health.

Over the course of its history, Wolston Park Hospital accepted and housed a diverse cohort of patients, including those with:

- psychiatric illnesses,
- intellectual disabilities,
- acquired brain injuries,
- psychogeriatric conditions,
- neurological disorders, and
- substance use disorders.

In the 1930s, the hospital opened two secure wards, Osler House (women) and Pearce House (men), to house criminals with severe mental health conditions, including those with and awaiting criminal conviction. These wards remained operational until the 1990s.

The 1960s and 1970s saw an increase in the criminal population of the hospital when people in detention deemed to have a mental illness were transferred from Boggo Road Gaol to fulfil their sentences. Patients often remained at Wolston Park Hospital for extended durations, with some spending decades in the institution. Within the Review Period, some of these patients were a holdover of prior societal attitudes which supported the institutionalisation of those with mental illness or disability in the absence of community alternatives. Social factors played a significant role in admissions, with many patients institutionalised due to poverty, homelessness or social isolation. Women and children were also vulnerable, with some admitted for reasons unrelated to mental illness, such as domestic violence or perceived behavioural issues. From the 1950s to the 1980s there are noted cases of children in the care of the State being placed in Wolston Park Hospital without mental health diagnoses and when deemed 'unmanageable' in foster care or other institutional settings.

The clinical approach to treating mental illness changed significantly throughout the history of Wolston Park Hospital. During the Review Period, the Hospital was shifting from a focus on custodial care and mental hygiene to a focus on managing symptoms. At the onset of the Review Period, treatments included electroconvulsive therapy (ECT), insulin coma therapy, and psychotropic medications. From the 1950s onwards, the facility transitioned to an approach of integrated psychiatric services that addressed underlying causes. The 1960s and 1970s saw the emergence of more progressive approaches, influenced by the deinstitutionalisation movement and advances in psychiatric research. Rehabilitation programs, occupational therapy and group therapy were introduced.

Despite this, in a 1994 report by John Hoult it was noted that:

> *"There is no avoiding the fact that Wolston Park Hospital on the Brisbane River at Wacol, 20 kilometres west of Brisbane, is Australia's largest and worst mental hospital."*
>
> ***Hoult, Burchmore, and Schizophrenia Australia Foundation, 1994, p. 261.***

The 1994 report further commented on the antiquated models of care and states of disrepair to be found in some of the older parts of the campus, particularly in Osler and Pearce Houses.

The mid-1990s saw the implementation of significant hospital reforms which led to wide-scale changes to the staffing model, the closure of several wards and an uptake in clinical safety measures. Project 300 (a planned approach to facilitate the discharge of longer-term patients of Queensland mental health institutions into the community) and the introduction of regional health services in Queensland played a major part in reforming Wolston Park Hospital. With the implementation of regionalised health services and Project 300, Wolston Park Hospital was able to re-route admissions and long-term patients so they could be treated closer to their homes of origin and in an appropriate hospital or community setting. The mass exodus of longer-term patients and altered clinical model led to the closure of what was the Wolston Park Hospital in 2000.

In 2001, some of the buildings on the site of the former Wolston Park Hospital were repurposed to accommodate the Park Centre for Mental Health Treatment, Research and Education. Since 2001, additional infrastructure has been constructed at the site to provide a limited number of mental health services including secure inpatient treatment, rehabilitation and mental health research. The former wards of Wolston Park Hospital are still standing, heritage listed but unoccupied and unused, providing a reminder of the history of the site and institutional care in Queensland.

3 Project scope and methodology

3.1 Terms of Reference

This project operated under the guidance of Terms of Reference (see *Appendix 1*) developed when the project commenced under the leadership of Professor Robert Bland AM with the support of Queensland Health. The Review acknowledges prior work undertaken by the Queensland Mental Health Commission in conducting consultation with former patients and residents of the Wolston Park Hospital, and their families and carers, to inform these Terms.

As per the Terms of Reference, the Review:

- Heard the stories of former patients and residents of Wolston Park Hospital and their family members or carers about experiences between the years 1950-2000 (the Review Period).
- Provides a thematic analysis of collected content to identify systemic issues, emerging themes and experiences of Wolston Park Hospital.

The Terms determined that the Review was to be about participants' stories - an opportunity for previously unheard voices to be heard. Based on prior statements from prospective participants that had been shared with the media, it was decided that the Review would need to be conducted in a trauma-informed manner to minimise the risk of causing harm to the wellbeing of participants.

The scope of the Terms of Reference does not include:

- The objective to determine the truth of participants' experiences, determine liability, recommend or facilitate financial compensation, judge participants or anyone mentioned by a participant or reach a definitive conclusion about what might or might not have happened at Wolston Park Hospital.
- The direct participation of former staff of Wolston Park Hospital, noting that some former staff and external experts were interviewed to provide context, background and understanding of the patient, family and carer experience during the Review Period.
- The ability to provide direct clinical assessments or care to participants, however it was determined that the Review would facilitate community-led support for participants as requested.
- Other mental health facilities or institutions in Queensland.
- Release of patient information to families.
- Consideration of the graves of former patients within the Goodna Cemetery.

As per the Terms of Reference, this Report provides a summary of experiences and thematic analyses relating to Wolston Park Hospital during the Review Period. It is an historical report and is not a reflection of current mental health or human services policy service provision or experience.

3.2 Informing the approach and process

To inform how the Review would be conducted, consultation was undertaken with several stakeholder groups:

Leading figures in the Queensland mental health field

- The **Queensland Mental Health Commissioner and their team** to understand the inception of the Review and the work undertaken prior to Queensland Health taking carriage of the process.

- The **Executive Director, Mental Health Alcohol and Other Drugs Branch** and **Chief Psychiatrist** of Queensland Health to understand impacts of the Review on consumers, staff and the whole service system.
- The **Chief Executive Officers** of the **Mental Health Lived Experience Peak Queensland** and **Arafmi** to support the design of the trauma-informed approach used in engaging people and families with lived experience of mental health.
- **Senior psychiatrists** and **mental health researchers** to discuss some of the historical aspects of mental health treatment in the institutional setting.

Hospital and Health Services

- The **Chief Executive of West Moreton Hospital and Health Service** and current executive of **The Park Centre for Mental Health Treatment, Research and Education** to understand the impacts of this Review into a facility for which they do not hold historical accountability.

Special interest groups

- The **Chief First Nations Health Officer, Queensland Health** and their Executive to foster an understanding of First Nations perspectives within the context of Wolston Park Hospital and in conducting the Review.
- The **Queensland Council for LGBTI Health** to understand LGBTIQ+ considerations within the context of Wolston Park Hospital and in conducting the Review.

Clayton Utz

- **Clayton Utz** provided support throughout the Review.

Queensland Health support

- The **Deputy Director-General of the System Policy and Planning Division** and the **Executive Director, Reform Office** supported the Review.

3.3 Trauma-informed approach

From the start of the Review, it was clear that many of those who wanted to tell their stories of Wolston Park Hospital carried deep and enduring trauma. As Lead Reviewer, I took very seriously the concerns expressed by responsible clinical leaders that the Review had the potential to re-traumatise the individuals who would come forward to participate. My Team and I developed a strategy that would address the risks to participants, described here as a trauma-informed approach. This process is described in detail in *Appendix 2*.

The Review recruited two senior social work practitioners who were leaders in the application of trauma-informed care in their work to develop and implement the trauma-informed approach used in the Review.

3.3.1 Implementing a trauma-informed approach

As registrations of interest were received, the Review made an initial assessment of the likely complexity of situations presented by participants. Participants who had been former patients and residents of Wolston

Park Hospital were identified as first priority and the Review committed to meeting with these participants in person. Family members and carers of former patients and residents were grouped according to complexity based on the information they provided at the time of registration.

The Review took a proactive approach to engaging with potential participants so that they were supported before, during and after the interviews. To support engagement, a four-step contact engagement process was designed:

Figure 1 - Four step contact engagement process used in the Review.

Interviews were conducted in person, wherever possible, rather than by phone. This required the Review to travel interstate and into regional Queensland to conduct interviews. Venues were chosen for convenience of participants and, where possible, based on surrounding features that would support a calming experience (for example, venues with lots of natural light, access to the outdoors and access to cafes or dining).

Participation in interview sessions was based on enabling the person to take control of telling their story and the way in which they did so. The Review opted to interview participants alone or with a carer or support person rather than conduct group interviews. While some participants did express a desire to meet as a group to discuss experiences, the Review was conscious of this not being conducive to the spirit of listening to and hearing individual experiences as described in the Terms of Reference.

3.4 Ethical considerations

The Review was aware of the level of trauma carried by participants who would meet with the Review. Managing the ethical issues that would emerge in the telling of experiences became central to the approach.

3.4.1 Consent

A detailed consent form was developed for use by all participants. It was important that participants understood the confidentiality of information that they shared and the risks of naming individuals. They were also informed of their capacity to withdraw consent at any time in the process. Participants were provided written information about the limited protections afforded to them by law under the Review. Participants understood and consented to these limitations, and were careful not to share information that they might want to stay private and confidential.

3.4.2 Psychosocial safety

The interviews allowed participants to share some deeply distressing stories of their experiences relating to Wolston Park Hospital. A participant might have given consent to be interviewed but become aware of the depth of their trauma once memories were revived. Based on the trauma-informed approach, it was made clear in conversations with participants that they could withdraw at any time or could take a break if needed. The trauma-informed approach also ensured that each participant had an established and solid supportive relationship with either the Assistant Reviewer, the Advanced Specialist Clinical Support Coordinator or the Program Manager. This was to support the management of any distress within an established supportive relationship and without a direct clinical interaction. As indicated in the Terms of Reference, the Review facilitated external support (for example, peer or psychologist counselling) for participants who requested it.

3.4.3 Referral and reporting responsibilities

As per the Terms of Reference, my job as Lead Reviewer and the job of the Review Team was not to determine the truth of any statements made to me. However, under Queensland legislation members of the Review

Team were obligated to escalate concerns of criminal or unethical behaviour that had been disclosed by participants of the Review. As such, any arising concerns of alleged historical misconduct within the Review Period have been deferred to the Ethical Standards Unit of the Queensland Health, and I am assured that these concerns are being handled within appropriate ethical and legal guidelines.

Specialist advice on managing the ethical issues was provided by Professor Donna McAuliffe who met regularly with the Review Team to review matters of concern.

3.5 Teamwork

The Review established an effective working team of six. including two independent external consultants and four Queensland Health employees.

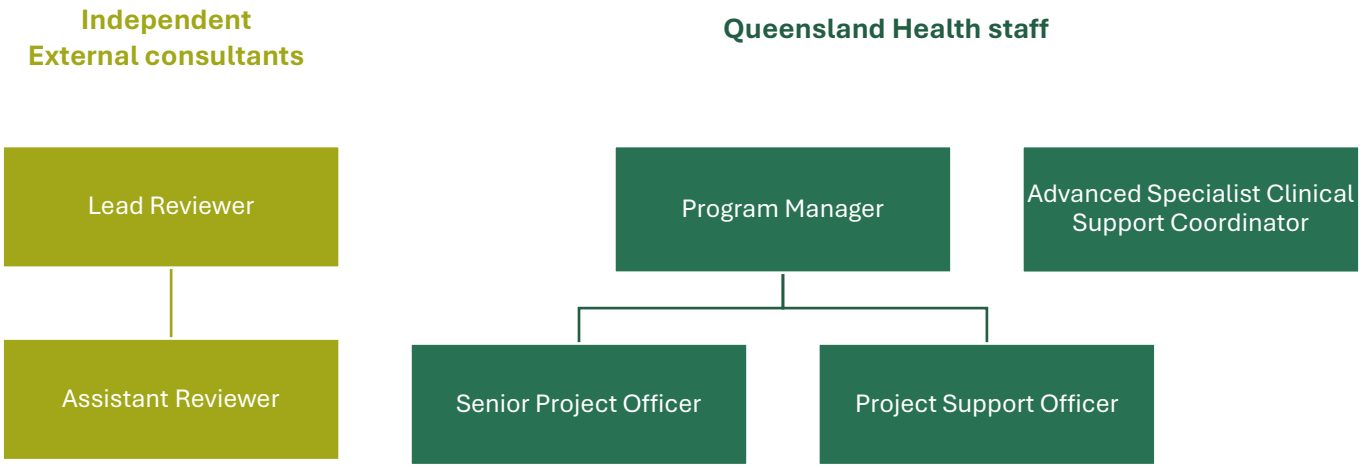

Figure 2 - Wolston Park Hospital Review Team roles

The Review Team had extensive discussions about how to conduct each of the interviews with participants. As Lead Reviewer, I attended all interviews accompanied by the Program Manager, the team member who was the primary contact with the participant before the session and a note taker. Every Review Team member in the participant interviews shared responsibility for creating a welcoming, safe environment for the participant. In my role as Lead Reviewer, I relied heavily on the advice of the Assistant Reviewer and Advanced Specialist Clinical Support Coordinator in determining a participant's readiness to meet with us and in any requests to provide necessary support. I leveraged the project officers to keep the Team focussed on the logistics of conducting the Review and developing this Report.

3.6 Building participation

From the outset, the Review considered that many of the potential participants for this process would be scattered throughout Australia. Given the historical nature of the Review, many former patients and residents of the Hospital have died, and there would be few survivors from the hospital patients there in the 1950-1960s. The time frame to conduct the Review (12 months) and did not allow for enough time to adopt a more aggressive outreach strategy that might have brought a greater diversity of voices. It was also considered that statewide or national broadcasting of this Review may have unintentionally triggered a trauma response in members of the community who did not wish to speak with the Review. As such, it was determined to rely on the initial announcement of the Review and word of mouth to build participation.

A core group of former patients and residents of Wolston Park Hospital, together with some families, had advocated strongly to establish a more formal legal review or inquiry. When the current storytelling approach was determined, the advocates for an inquiry formed the starting point for recruiting participation. Some initial media interest led to a surge of interest and subsequent registrations for participation in the Review.

While former staff of the Wolston Park Hospital were not described in the scope of the Terms of Reference, the former clinical and non-clinical personnel who volunteered to participate were interviewed to provide context, background and understanding of the patient, family and carer experience.

As Lead Reviewer, I invited historians, key mental health leaders and former Wolston Park Hospital senior staff to share their knowledge with us as a strategy to better understand the history and culture of the hospital. Their contributions added a richness to the information gathered in the Review.

3.6.1 Participation statistics

The Review did not have a representative sample of participants. A diverse range of people were welcomed to participate, all of whom had a strong investment in the Review as a way of informing the government and the public of their experiences of the Wolston Park Hospital.

Participation

83	66	26
People registered interest *	People were interviewed	Written submissions received (from interview participants – See Appendix 4)

Relationship to Wolston Park Hospital

14	25	18	9
Former patients	Family members	Former staff	Special interest (historians and community members)

Interviews

66%	14%	20%
Conducted in South-East Queensland	Conducted in broader Queensland or interstate	Conducted virtually

* 17 registrants did not proceed to interview for at least one of the following reasons:

- They withdrew after considering their wellbeing or determining that the process would not be of value to them.
- They were only interested in updates on the progress of the Review and did not wish to be interviewed.
- They were out of scope due their lived experience being associated with a different institution or time frame.
- There were interested in accessing family member records from Wolston Park Hospital. This was not in scope for the Review, however these people were provided with information about how to do this under the *Right to Information Act 2009 (Qld)*.

3.7 Thematic analysis

All formal interview sessions were recorded and transcribed with participants' consent. The Review undertook an inductive methodology to draw the information shared at the interviews into key themes, and the transcripts were then coded and analysed against this methodology. The summary of themes has informed how the information heard from participants has been presented in this Report. Information gathered at interviews that was outside the Terms of Reference for the Review has not been reported (for example, stories relating to other institutions or outside of the Review Period).

3.8 De-identification of participants

The Terms of Reference specify that individuals who participated in or were named in the course of the Review will not be named publicly or within this Report. The names of patients, family members and former staff of Wolston Park Hospital, including those who might be identified by their title, have not been included within this Report.

4 Underlying principles that shaped the Review

This section outlines the key principles that shaped the Review–how it was conducted and how the information received was analysed–and how these principles emerged following the interviews. Together with the commitment to the trauma-informed approach of the Review, the principles outlined below capture the approach the Review took to working with participants and producing the Report. They also provide the lens through which this Report should be read. These principles are:

- The centrality of lived experience of mental illness and care as a focus of study.
- The importance of listening and hearing.
- The Review: For us or for them?
- That was then, this is now.
- The illness or the treatment?

4.1 Valuing lived experience

One of the central tenets of mental health policy and recovery-oriented practice is the importance of valuing the lived experience of consumers and families. At one level this is about engaging in a dialogue with those with a lived experience of mental illness and seeking to understand that experience at a deep level. But the experience of illness includes the experience of treatment, and it includes the wider impact of the illness on those around the individual. It includes the lived experience of health professionals. It includes the consequences of illness and treatments – the stigma, the lack of opportunity to live a fulfilling life, and the threats to education, employment, income security, and intimate relationships.

The Review provided an opportunity for participants to share their experiences of illness and treatments at Wolston Park Hospital over the 50 years of the Review Period. This process was a commitment to valuing the lived experience of patients, family members and carers, and involved a process of respectful exploration of that experience. The stories of life in the hospital, the treatments, the disruptions to ordinary family and community life – this is the stuff of lived experience. The Review provided an opportunity to engage with the lived experience in a bottom-up way. It was an opportunity to privilege the lived experience of patients and families and to inform an understanding of the systemic issues of patient care.

4.2 Listening and hearing

> *You return to that earlier time armed with the present, and no matter how dark that world was, you do not leave it unlit. You take your adult self with you. It is not a reliving, but a re-witnessing.*
>
> ***Michael Ondaatje Warlight***

The *New Zealand Report of the Confidential Forum for Former In-Patients of Psychiatric Hospitals* (Mahoney et al. 2007), on which this Review was modelled, was conducted over 3 years and interviewed 493 people. That report lists only a few recommendations, insisting that the real value of the New Zealand review was in hearing the voices of individuals with a lived experience of mental illness in treatment facilities. The process of speaking and listening is a valuable outcome in its own right.

There are two parts to a storytelling process:

1. **The first is the speaking of personal truth** – the opportunity to tell one's personal and unheard experience in a public place before authority figures.

2. **The second part is the responsibility to listen** and to respect that truth. It involves an active role for both parties – the speakers and the listeners.

In this Review, the speakers were those who had lived experience of treatment in Wolston Park Hospital, either as patients or as families and carers of patients. The listeners were the Lead Reviewer and the Review Team. At a deeper level the listeners are also the broader community – the law makers, the mental health services and the broader public. As witnesses to the lived experience of those who met with the Review, some very painful stories were heard. It was not the job of the Lead Reviewer or the Review Team to interrogate the subjective truth of the stories, to determine an objective truth, or to offer explanations for why people might have had specific adverse experiences. The obligation was to listen, not aways comfortably, to the stories that were shared.

An example of this would be the common story of the very unpleasant effects of the medication given to patients. Medication compliance is a central tenet of mental health care. However, many former patients shared about the very negative experience of taking antipsychotic medication. They said they felt like zombies. They said that medication was given to punish bad behaviour. They said that ECT was given against their will and in a very distressing manner. The Review listened sympathetically and uncritically to these patient descriptions and realised that their lived experience of taking these medications was that it was distressing and depersonalising.

4.3 For us, or for them?

The sick are ourselves. Ourselves. When you stop understanding that, take your name off the wall and throw your bag in the river.

Niall Williams, The Time of the Child

The people who were admitted to Wolston Park Hospital over the Review Period received care in the context of care and treatment models that applied at the time. Most people who had a positive or short experience of care did not engage with the Review process. Many of the participants interviewed were those who felt they had been badly dealt with in their care, who have survived the experience, and who were determined that their voices be heard. Quite a few of those whom the Review spoke to insisted that they wanted to speak for those who could not speak for themselves – those who had passed away in the years since Wolston Park Hospital closed, or those who were not able to come forward for personal reasons. They named individuals, their friends in the hospital, who they said were abused by staff.

At one level the Review was about the direct experiences of former patients and their families and carers. But there is another way of thinking about Wolston Park Hospital as it functioned for so long, as a place where patients were received and warehoused in isolation from their families and communities. The broader community enjoyed the benefit of avoiding responsibility for their care, or for caring about them.

Without specialist care for people with intellectual disability, epilepsy, autism or behavioural disturbance based on a failure of family care, all roads led to the psychiatric hospital. The Review is also about reminding the community of its own failings, of its reluctance to demand to know what happened to the people they sent to the hospital.

This Report is as much about the systems of care over the Review Period as it is about the experience of individuals and their families.

4.4 That was then, this is now.

"The past is never dead. It's not even past."

William Faulkner, Requiem for a Nun

As Faulkner reminds us, there is a sense that the grief experienced by former patients and their families have not been settled by the passing of time. The abuse described by so many of the former patients is still very present in their lives. The Review heard of trauma experienced by children in Wolston Park Hospital, and of sexual violence inflicted on them by the staff charged to care and protect them. Similarly, there is a sense of gratitude to individual staff who stepped in to help people at times of great need. Both the good and the bad are held in living memory.

The Review is not simply about past experiences from which individuals have moved on. It is about the way that these experiences continue to shape the lives of individuals.

4.5 The illness or the treatment?

Listening to and reading the experiences of people who were patients at Wolston Park Hospital challenges the community to consider what part of that experience is based on the mental illness itself, and what part is about the way people were treated. The illness can be isolating, terrifying and humiliating. People report feeling a loss of personal identity and sense of agency. Even with the best care the experience of illness is very distressing. To that is added, through hospitalisation and treatment, the separation from family and community, loss of education and employment, and poverty. Drawing conclusions about the impact of care is difficult when much of the distress experienced can be attributed to the mental illness itself.

5 Summary of information provided by participants of the Review

This chapter provides an overview of participant's stories and information heard by the Review. Some of these stories have been referenced in the public record, either as a part of the Taylor (2017) or Chynoweth (2017) reports or in media where former patients have shared their stories publicly. There were also new perspectives shared with the Review: those of family members who are still living with the impacts of familial mental illness generations on and those of the workers and leaders of Wolston Park Hospital. This Report draws together the stories of participants and presents them in a thematic way.

The information provided has been grouped into the following sub-chapters:

- Culture and governance,
- Medication, ECT and treatment,
- Sexual and physical violence,
- Families,
- Supportive individuals made a difference,
- Positive levers for change, and
- Conclusion.

It is important for the Report to reiterate that the following information pertains to the historical period of 1950-2000 and is relevant only to experiences within Wolston Park Hospital. This Chapter does not reflect experiences of current clinical practice or policy within the Queensland mental health system and other human services.

I am conscious that most former patients of Wolston Park Hospital and their families or carers did not speak to the Review, either because they are not here to represent themselves, they do not have the ability or the desire to come forward, or because they were unaware of this process.

This Review was based on the information provided by individuals, and my task as Lead Reviewer has been to draw on the information provided and report that individual, personal experience. The Chapter that follows cannot claim to be comprehensive or objective. It represents the voices of individuals who shared their experience because they wanted to share it with those who would listen to them.

I am not required to determine the objective truth of any of the information provided, either by patients, families or carers. Without the ability to test the information and claims in a judicial process, I cannot draw conclusions that attribute blame to anyone. I am cautious too about assigning virtue to individuals.

5.1 A starting point

Many of the participants, even those with very bad experience of their time at Wolston Park Hospital shared that most of the staff were caring, professional people who did their work diligently. As Lead Reviewer, I feel an obligation to acknowledge this as a starting point. I am aware that some of the following content may reflect badly on the staff of Wolston Park Hospital as a whole. The Review process provided a place for participants with experiences or a grievance against the hospital to be heard, and their voices were heard clearly and strongly by the Review. Very few people who were pleased with the care that they or their family member received felt the need to share their experience with the Review.

5.2 Culture and governance

As set out in the *Chapter 2*, there were huge changes over the five decades of the Review Period. It is impossible to talk about the culture and day-to-day life of 50 years of patients in Wolston Park Hospital as though it was a single entity. During those years there were changes in:

- staff training,
- the workforce, which broadened to include allied health staff,
- the patient profile and purpose of many of the wards,
- the numbers of patients living at the Hospital - increasing and then steadily decreasing,
- mental health legislation that governed admission and discharge processes, and
- the treatments available to clinicians.

The Review identified key historical reports and invited the participation of local historians who informed the Review's contextual understanding of the Wolston Park Hospital. The Review relied on the information provided by former staff to understand how the hospital functioned. This included an invitation to former leaders in nursing, medical and research fields to provide an overview of the last 20 years of Wolston Park Hospital. There was one personal account of the hospital in the 1950s and very few about the 1960s. There are significant gaps in knowledge because many of the key figures who held leadership roles in the hospital and in the Head Office of Queensland Health from the 1970s have died.

Certain key historical developments over the Review Period—as shared by the participants who were former staff over the Review Period—can be identified as shaping the operations of Wolston Park Hospital and the lived experience of patients. These developments are also reflected in the history of mental health institutions elsewhere in Australia and internationally. They include:

Integration of wards	The integration of wards so that most included a mix of male and female patients and staff. Certain wards remained men only (Pearce House) or women only (Osler House). For most of the Review Period, Pearce House was staffed only by male nurses, while Osler House had a mixture of male and female nurses to care for the female patients. Prior to the integration of staffing, the hospital was administered almost as two separate gendered faciliies governed by nursing leaders of the corresponding gender. By 1970, nursing leadership was centralised into one position.
Separation of patient cohorts	The separation of a very diagnostically diverse patient population into specialist treatment units. The removal of intellectually disabled residents, including children, from psychiatric wards had been largely achieved before 1970. These residents were cared for in specialist facilities such as the Basil Stafford Centre and were no longer under the care of Queensland Health. Specialist units introduced during the Review Period included the Barrett Centre, a new admission ward with a strong focus on modern mental health treatment (opened in 1979), an adolescent centre (1984), a research unit (1987), and rehabilitation wards.
Diversification of the workforce	The diversification of the traditional medical and nursing workforce model to include substantial numbers of allied health staff – social workers, psychologists and occupational therapists. These staff challenged the custodial focus of the hospital and offered a therapeutic alternative to traditional medical and nursing care.

Mental health legislation	Changes in mental health legislation from the 1970s brought systemic review of involuntary care and greater reliance on voluntary admission.
Psychotic illness medications	Developments in medications available to treat psychotic illness. The Report discusses the patient experience of medication, ECT and treatment in *Chapter 5.3*.
Access to Commonwealth social security payments	The access to Commonwealth social security payments for individual patients and residents (both the Sickness Benefit Pension and the Invalid Pension) in 1972, which gave patients in long-stay wards a low income that allowed them to buy their own clothing and personal items.
The Nurse Training School	The establishment of the Nurse Training School within Wolston Park Hospital in the 1960s, which significantly improved the training of nursing staff and provided a professional pathway for mental health nursing as a profession.
Regionalisation of health services	Regionalisation of health services in Queensland in 1991, which provided a basis for Wolston Park Hospital to insist that the regional health services could no longer rely on transferring the most difficult patients to a central point of care and that Wolston Park Hospital would stop being a warehouse for the most difficult to care for patients.

5.2.1 Hospital governance and culture

The Review heard only one account of the staff culture at Wolston Park Hospital in the 1950s. A nurse who worked there at the time shared that there was a distinct difference between the male nurse who were mostly 'family men', more relaxed and more caring, and female nurses who were usually single women, many of whom lived on-site in the nurses' quarters and who included refugees from Europe and former Australian prisoners of war. The female nurses of this era were described as more regimented and less compassionate. Many could not speak English. This nurse described a close connection between the nurses, many of whom lived in Goodna, and hospital patients. Families provided cakes and fruit for the patients in the wards where staff worked.

Former patients and staff who were interviewed were consistent in associating power in the hospital with the nursing staff. One nurse from the 1980s told us:

> *The [ward-level] nurses were enormously powerful. If a doctor said, "I want to transfer this patient", and the nurse said no, "I don't want that patient", it didn't matter what the doctor said. The nurses ran the whole Park.*

The Review heard of a system of rostering of nurses so that the same staff ran the individual wards, and that this system centralised power in the hands of nurses in charge of each shift on the wards. Participants described this centralised power as most obvious and most problematic in the locked secure wards of Osler House and Pearce House.

A former social worker spoke of the dominance of the nurses in Pearce House during the late 1970s. They noted that they were the only social worker in the ward, and that medical staff were largely absent:

> *Nurses were very much the dominant group, and they very much had the power. The other impression that I had was of the power structure centred around the nurses just protecting the nurses against the patients. It was almost as though the patients were the enemy.*

The power of the nursing hierarchy is mirrored in the relative absence of medical staff in Osler House and Pearce House that was described by participants. The Review heard from a former patient who said it was clear that the nurses controlled Osler House:

> *You would see a doctor if there was an injury that hadn't been reported and then that was all covered up anyway, so, no I didn't see a doctor in Osler House.*

They couldn't recall seeing a social worker either:

> *But it didn't matter whether they were there or not, because their hands were tied, couldn't do anything about [the treatment we received], too scared to do anything about it, or they're in on it. That's how I saw it.*

The participants interviewed expressed a view that the hospital management were largely ineffective in directing the work of the hospital. Speaking of the leadership situation in the 1980s, a former nurse said:

> *They didn't do much. The people at the top weren't there to make any changes. I can say it was more a groundswell from the bottom up.*

The Review heard that the administration of Wolston Park Hospital was hindered by the governance of the Head Office of Psychiatric Services, Queensland Health. There was a sense of the hospital being under siege from Head Office in a way that the other major Queensland psychiatric hospital, Baillie Henderson, was not:

> *At that time there was a [hospital executive] who ran the hospital locally, but people would come out from town and say they're going to re-organise over the weekend...So it was kind of ruled very remotely.*

Participants who were former patients and families also described the power of particular staff within the wards. They described that they observed a culture of staff protecting each other, and of manufacturing stories, which allowed staff to avoid accountability for their behaviours towards patients. Many participants further described that when they escalated concerns of treatment to hospital staff or management, their concerns went unanswered, were explained away, or came with threat of reprisal.

One participant described witnessing the staff bullying and intimidating of their loved one in Pearce House. When they objected, they were threatened by the staff of the ward:

> *...he told me that I was never to tell anyone what I saw and that's when he said, "I'll send you into Osler House with 16-year-olds if you ever tell anyone".*

The Review heard stories from former patients that a fear of union action was given as a reason for failing to discipline staff who treated patients badly. A participant who witnessed a serious physical assault on another patient provided an example of management's failure to confront concerns and complaints directly. The participant told the Review they were prevented from giving evidence in court by a senior member of the hospital staff, despite being willing and able to do so, because:

> *... [They] said that if he's [the staff member] convicted "I will have a strike on my hands".*

The participant told the Review that the case collapsed without them as a witness and that the staff member was able to resign without any charges and found work immediately at a local aged care facility.

5.2.2 Poor physical structures and clinical models

An ongoing issue described by patients and staff was the very poor physical condition of certain wards in the hospital. This was highlighted in the Hoult Report (1994), where the investigator assessing the situation at Wolston Park Hospital described the physical condition of Osler and Pearce Houses as probably the worst in Australia. When a new senior administrator was appointed to the hospital in the 1990s, they were shocked to find that the roof in Pearce House leaked so badly that tarpaulins were used to stop the rain coming in to patient living areas.

The Review heard that up till the early 1990s there were few clear therapeutic modes of treatment or rehabilitation applied in the older wards of Wolston Park Hospital. The Barrett Centre, which opened in 1979, functioned as an acute treatment and assessment unit comparable to other such units around the State. Many of the wards outside of the Barrett Centre complex housed an ageing patient population and retained a custodial approach to care where there was little expectation that patients would receive the therapeutic interventions needed to leave hospital.

The Review was told by a former administrator:

> *The problem was nobody was clear about what they were doing there. There were no sophisticated models or expectations for evaluation and measurement. There were no efforts at rehabilitation.*

They argued for high intensity transitional work to support people moving back to the community:

> *There was nothing like that at the Park. It was all just [an] idiosyncratic sort of traditional ward.*

Throughout the 1970s, the placement of patients out of hospital into community living situations, particularly into privately run boarding houses, was a feature of the work of the after-care nurses and the social workers associated with Wolston Park Hospital. The Review heard very little information about this process from the participants who met with the Review. Over the Review Period, allied health staff such as social workers and occupational therapists contributed to the transition of the Wolston Park Hospital from a purely medical and nursing facility to a more therapeutic rehabilitation focus. A number of former Wolston Park Hospital social workers interviewed for the Review concluded that, until later in the 1990s, their work was challenging, lacking in a clear focus, and was often contested by nursing and medical teams. Professional supervision was limited. One participant was tasked with providing social work services in Pearce House in the late 1970s. They described a lack of patient activities in this ward, so they started to bring in newspapers and run small yoga classes to occupy the patient's time. Their capacity to continue to make small changes to life in the ward for the men there is testament to their professionalism.

A former social worker at Wolston Park Hospital described how in the late 1980s and 1990s, allied health staff gradually moved in to work at Pearce House and were able to focus on preparation for patient discharge through Project 300 (discussed in *Chapter 5.7.3*). This enabled them to focus on working with families, as well as patients, to enable appropriate discharge of patients into the community. The last decade of social work at Wolston Park Hospital was described to be more focussed on the social context and consequences of mental illness, in line with social work theory of the time. The Review heard that occupational therapists were valued by patients as providing a focus on skills for daily living. The Review did not speak to either occupational therapists or psychologists but was made aware of their presence in Wolston Park Hospital during the Review Period. Two psychologists were named as providing very valued personal support by former patients interviewed for the Review.

In summary, the patients and family members that the Review heard from described a situation of poor governance until the mid-1990s, where power was exercised largely at the ward level. The changes in leadership at both medical and nursing areas, and the growth of the allied health teams, were described as the catalyst for the major reforms that led to the closure of the hospital and improved outcomes for patients and their families.

5.3 Medication, electroconvulsive therapy (ECT) and treatment

A consistent message heard from participants was the extensive use of medication to control not just the symptoms of psychotic illness, but the behaviour of difficult-to-manage patients. The Review heard many stories of patients being over-medicated on drugs that caused them to be heavily sedated:

> *There was the case of being over-medicated and put in a room with no windows, and there's a mattress on the floor and being force fed medication in food and then, when you were allowed out, you were unable to see, you were so blinded by drugs.*

> *I was on Haloperidol, and I think just about everyone was on Haloperidol. That's when you're just walking around like a zombie. You'd wake up in the morning because you've actually peed the bed, you know what I mean. You'd sleep through the urge to get up and go.*

> *I was never told anything extra was added ... [but] it would knock me out straight away. I couldn't even get to my room before passing out... It felt like they were using medication to control us.*

> *A lot of the other people were on this stuff all of the time, day in, day out and some of them were just walking around like zombies, crying. The crying never stopped. [...] but medication was, I don't know whether it was necessary for everybody, but I know it wasn't for me.*

Family members struggled to accept the changes to their loved ones caused by the medications and other treatments at Wolston Park Hospital:

> *When I visited him, he was not the [brother] I knew. He was catatonic...I think it's the medication doing this. And [I asked] for them to stop the medication. But I don't know whether they did. The nurses seemed to be in control what happened on the ward. They used to walk around with syringes of Largactil in their pockets. They were armed permanently.*

> *[Our mother] was subjected to heavy medication for depression and anxiety, ECT, insulin shock therapy which induced coma. In the period of one month, she went from 0 to 32 comas.*

> *The first time Dad and I saw her ... she was just drugged out of her eyeballs.*

One common reported side effect of the medication, apart from the heavy sedation and lethargy, was weight gain.

The Review heard from many patients and family members about the impact of having ECT, and the over-use of the treatment as a way of punishing bad behaviour. The efficacy and processes of administration of ECT have improved significantly over the years, but the descriptions of ECT treatments at Wolston Park Hospital during the Review Period that were provided to the Review are graphic and disturbing:

> *They had a big room where all the beds were lined up and you had your head at the end, not the pillow end, and they brought the machine down the line, and I was terrified to know or see what happened, so I closed my eyes...I knew what happened but I didn't want to see it. And you'd wake up at the table having a vegemite sandwich.*

> *We had electric shock days...The people were lined up, sort of lined up. And then they would get down on the bed. Nurses on both sides were holding them while they got the shots...and then they'd be up again and then they'd have the shock treatment cake. I'll never forget that cake. They were given a piece of that and a cup of tea out of a huge pot. That was the shock treatment day...It was a Thursday.*

Some of the participants who were former patients claimed that they had been misdiagnosed either before or at the point of admission to Wolston Park Hospital. The participants who were inappropriately placed in Wolston Park Hospital as children described being treated with medications and seclusion, some even ECT, though they did not suffer from any mental illness. Another participant shared that their mother was misdiagnosed with Huntington's Disease, leaving their family members with very uncomfortable choices

about whether to have children and risk passing on the disease. When their mother died, an autopsy revealed that she had not had the disease, but this information was shared too late to prevent a lot of family anguish. The Review heard from family members who were hungry for information about the diagnoses applied to family members while they were at Wolston Park Hospital. This information was not readily shared with family members by Wolston Park Hospital staff. Diagnoses were, and still are, sometimes disputed by family.

In one situation shared with the Review, a pair of siblings described how their mother had been admitted to Wolston Park Hospital, possibly with depression. The family lived in a very remote location. Their father had taken a mistress into the house after their mother was admitted to Wolston Park Hospital. The treatment team asserted that this belief about the husband's infidelity was a delusion and the patient's discharge was delayed because the staff would not accept the patient's protests that situation was true. The patient was only considered for discharge after they falsely conceded to Wolston Park Hospital staff that the concerns of infidelity were a delusion.

In summary, many of the participants were critical of the treatments provided at Wolston Park Hospital. The history of the hospital shows the emergence of new and better medications for the treatment of mental illness, allowing treatment staff to use more targeted drugs with fewer side effects in the later years of the Review Period. When only a few antipsychotic medications were available from the 1960s to the 1980s, clinical staff had few treatment options. The side effects of the medication were awful for many patients. As one participant with a clinical background told us, while modern drugs are more effective, the side effects of medication continue to be unpleasant. When ECT was administered in the manner described by former patients, the experience of receiving the treatment must have been very frightening.

It is beyond the scope of this Review to reach conclusions about the appropriateness of medical treatment provided to patients. Almost certainly for the majority of the patients, the treatments provided were considered good practice at the time, poor though these practices might have been. There is a consistent message in the stories shared by patients as part of the Review that their experience of both medication and ECT was unpleasant and invasive. The Review heard from former staff who said that medication was used to control behaviour, even for those who did not have mental illness.

As Lead Reviewer, I am left with the realisation that for many patients, both the experience of mental illness and the treatments provided during the Review Period were very unpleasant. Hospitalisation was experienced as imprisonment. Seclusion and clinical treatments were experienced as punishments. The trauma experienced by individuals is compounded by witnessing the distress of other patients around them. I am aware that those the Review interviewed spoke for themselves and that I cannot comment on the general experience of the hospital or treatments based on the selective sample of former patients that the Review interviewed.

5.4 Sexual and physical violence

Many of the former patients that the Review heard from spoke of sexual and physical violence. All of the participants who had been children at the time of their placement at Wolston Park Hospital reported being sexually assaulted. Some of the participants who met with the Review had told their stories in earlier hearings and the details of their abuse are documented in the *Queensland Government Reconciliation Plan: Stage 1* report (2017). Other former patients who were juveniles at the time of their admission had similar stories of abuse. Family members shared stories of abuse of their loved ones in Wolston Park Hospital.

The Review has chosen to use the term 'sexual violence' in this Chapter to cover the range of abuses described by the participants. This includes rape and non-penetrative sexual acts. The Chapter will provide examples of sexual violence as described by the participants. This has been done to honour the courage of these individuals who shared these stories with the Review and for whom the trauma of these experiences endures in their bodies and their spirits. They shared their stories bravely, and it is important that the Review

recount their experience as described and with honesty. Not all the participants who reported being physically abused also reported being sexually abused. Some of the physical abuse was described as systemic in nature, directed against all the patients in the ward, and not to individuals. All of the participants who reported sexual violence reported associated physical abuse.

As Lead Reviewer, I do not have the mandate under the Terms of Reference of the Review to comment on the facts or trustworthiness of the stories the Review heard. My task was to listen to participants with openness and compassion, and to allow participants to share their experiences. These stories were painful to tell, and painful to hear. No doubt they will be painful to read about too. I will present an overview of the stories of sexual and physical violence and try to draw some observations at the end of this Chapter.

Most stories shared about Osler and Pearce Houses came from participants or their family members who were placed in these wards for environmental isolation and not criminal offending. There were several reports of sexual violence in Osler House where both criminal female patients and the women and girls from other wards who were placed there were overseen by both male and female nurses:

> *And if you didn't suck their penis... If you didn't do what they wanted you to do, it was beyond, and they actually forced us to do it. We had no say in the matter. [...] I need justice because a young kid, that fucks them up for good. I'm an adult, sixty-four, and I'm never going to forget. It still haunts me...*

> *At Wolston Park [we] were bashed and raped and medicated and they were fed Paraldehyde.*

The Review heard from a former patient who spoke of the pervading atmosphere of violence in Osler House:

> *If it wasn't happening to me, you were watching it happen to someone else. I was beaten. I was raped. I was sodomised. I was pissed on. I had objects used against me. I was verbally assaulted. Physically. Mentally. All due to a drug called Largactil. You're a zombie mate. They can do and say what they want. You don't really get a full idea of what's happening to you till after.*

In describing their experience of Osler House, one participant shared:

> *People were allowed to rape me and do whatever they wanted and not one of them ever had to answer for it.*

The Review heard from one former patient who felt they needed to provide sexual favours to staff in return for safety and comfort in Osler House:

> *I didn't want it, and in some ways it seemed worse. But it seemed the lesser of two evils: Being bashed within an inch of my life at times, or sex.*

One of the participants, who was a former patient, explained to the Review that they knew when a staff member wanted sex because they would hang a towel over the door to their room. This participant recalled that another staff member brought a bottle of Asti Spumante to their room as a sign of his expectation that they would have sex.

Boys were also vulnerable to sexual violence. One of the most harrowing stories came from a participant who was admitted as a patient in the 1960s, while a minor. The participant described in graphic detail how they were raped, and how other boys in the ward were systematically raped, by male staff. The participant described their first experience of rape by male staff:

> *I had three of them just doing what they normally do, what they wanted to do. He told me get used to this. This is going to happen at least twice a week.*

They described the rape of another boy and a culture of abuse in disturbing detail:

> *Here he is, this big, fat, pig, screwing a 12-year-old autistic boy tied up to an aerobics bar.*

> *There were many times that the wardens would come down, maybe one or two o'clock in the morning and wake you up, and say, get up. They'd take me to...where they all were, and here they were, no pants on, having a wank or whatever the case, get down there...giving oral sex to them. You know, don't say no, because when I did say no, they'd take me and pull out my file. Is that your name? right and then you'd have 12 ECT sessions, and if I didn't give oral sex to them, they'd put on another three sessions and it just kept going up.*

> *Out of the 30 odd boys, there were only about 13 or 14 who ever had it done to them. When one guy got you, and he liked you. That's it, you were his boy for the rest of the time you were there.*

This participant's account is detailed and confronting. The story describes the systemic nature of the violence experienced.

There were reports from a family member about the rape of their young brother in Pearce House. The Review heard that their brother, a minor at the time, was forced to rely on the protection of a ward nurse for his safety from other dangerous patients:

> *He had been told that he had to have sex with the nurse in return for protection. [He] would always have to be at the end of the line in the showers because if he wasn't at the end of the line, he was the one who was being raped by all the others, or if he was at the end of the line he was the bum boy for the nurse...And that is what [he] had to do to survive. He was in that place for 10 weeks.*

The Review heard from participants about a culture of rape and sexual assault in some wards. A participant recounted that there were just a few staff members who committed sexual violence, but that there was a sense the other staff were aware but not strong enough to influence the others or do anything about it. A

participant who was a former patient recalled that a staff member acknowledged the abuse they were experiencing but conceded:

> *[He said] "If I say something, they won't back me up, they're all against me, and I'll get out of a job" and he said I've got a young family, 'cause he'd just had a child.*

Another former patient described the attitudes of staff towards sexual and physical violence, and a culture which they perceived protected the staff:

> *If it was a patient raping us or beating us or doing whatever they wanted: "It's not their fault. They can't help it. You're lucky you're not sick like them." If it was a staff member [they'd say]: "Oh that's just a mistake they've made. It will affect the whole career, they've worked so hard."*

The were several accounts of physical violence among the stories heard by the Review. There are accounts of individual physical abuse, and others which described a pattern of control in some wards that relied heavily on physical violence. It is acknowledged that controlling a group of very unwell and aggressive patients required nurses to use physical restraint. As described by participants, physical restraint that inflicts fear should not be used to maintain safety on a ward, and it needs to be balanced with respect and compassion:

> *Physical abuse was common, being manhandled and physically restrained, being grabbed and forced into time-out was common.*

> *I'm in the showers one morning. This fella has got a razor blade, and he's held it to my throat. He was going to cut my throat, while these two nurses are bashing the shit out of an older guy who shouldn't have ever been in there and they were really flogging him. And I was wondering why he was always black and blue.*

One participant described a significant beating that they received while a patient, and a culture within Wolston Park Hospital which ignored the violence:

> *When I woke up, I couldn't see, I thought I was blind, and I could barely talk. [...] And then probably by about day two or three I could see just a little bit out of my eye. I looked in the mirror and I had no face, had no nose... And so by the time all the swelling went down [...] I saw a doctor, but I still had a lot of bruising, and I don't know what they said but in amongst it all I lost my voice. ... Not one person asked what happened to this patient.*

Another participant who was a former patient described that violence against patients happened in the open. They described an assault against another patient happening in the yard of Osler House with other patients and staff present:

> *I think she [the patient] was in her 50's, or maybe 60s you know, she was bashing at the door one day and bashing it because the priest was there. All she wanted to see was the priest. They [the staff] knocked her head into the cement wall and kept knocking it and bashing it.*

Another former patient of Osler House said:

> *Nobody in there deserved any brutality at all and those handicapped people who were severely handicapped, well everybody. A lot of people in there would never have understood why. Why were they being brutalised, why were they being bashed?*

The routines described in Osler House established a systemic pattern of sexualised humiliation. A former patient described the shower routine as follows:

> *All the doors were open at 6.00 am. Everyone came out of their rooms. There's three shower cubicles. We'd all have to strip naked, line up in the hallway and into the bathroom and two by two, everybody had showers. There was no toilet doors. There was no shower curtains. But you kind of think well because it's an all-female ward they only have women there. Women staff while women are showering. NO. The men would all be there too and you'd listen to their snide remarks…It was humiliating and degrading.*

The Review heard from multiple participants who described that staff would direct fire hoses at patients to clean them. One participant recalled a fellow patient in Osler House who had dementia and would frequently soil herself and her room overnight:

> *It got to the point where the staff were getting the shits and her door was near the fire extinguisher, the fire hose, so they'd turn the fire hose on, open her door and shoot her across the room with the force of the fire hose … She was just a frail old woman.*

A participant told us that their brother was regularly bashed in Pearce House. They described an incident when he made a formal complaint of staff violence:

> *That day, that nurse almost killed him…There were two witnesses. One who agreed with [his] version, and the other who just vaguely said no, I don't think it was that way. But they clearly had a massive problem, and they didn't do anything about that nurse, but they knew that [my brother] was serious and I think they thought if they didn't move him, he would be killed.*

Another family member described that their brother experienced violence at the hands of a staff member while in McDonnell House, resulting in up to 40 stitches in his head:

[A staff member] has literally chased him and beaten him from one end of McDonnell House to the other. So he's running for fear [...] up this spiral staircase and he's hanging on. [My brother is] hanging on so tight and that [the staff member] gets him and just flips him over it and he falls to the ground and then he has this huge injury.

The Review also heard from participants that the violent murder of a patient by a patient within the grounds of Wolston Park Hospital caused significant trauma to both patients and staff, as did the way the murder was handled within the Hospital.

For the participants who shared their stories of violence, their experience was profound and enduring. The patient stories and the reports from family members provide consistent themes of sexual violence at Wolston Park Hospital, particularly in Osler and Pearce Houses. There is a further theme of a culture of secrecy and protectionism, which served to perpetuate the violence.

The stories heard by the Review indicate the importance of having processes and healthcare practices that give regard to the power that clinicians and residential care staff hold, and the vulnerability that patients and residential care clients experience. There must be a patient centred approach to healthcare, particularly in residential settings. This is discussed more in *Chapter 6* which outlines the emergent themes from the Review.

The women and men who shared experiences of childhood sexual abuse – in a place that should have afforded them safety and care – described a life dominated by complex trauma and difficulty accessing Government health and mental health support due to the context in which the abuse occurred. That they have also survived and enjoyed some success in life, is testament to the resilience of their spirits.

5.5 Families

Of the 66 participants interviewed for the Review, 25 were family members, mostly children or siblings of former patients. The Review heard from one parent of a former patient. Four of the family members that the Review heard from described the impact of the hospitalisation of a grandparent or great grandparent on subsequent generations. The stories heard by the Review indicated that the presence of family was a protective factor for patients at Wolston Park Hospital. The Review heard that where individual patients had a negative experience at Wolston Park Hospital, it typically had a negative impact on their family, either during the admission or in the years afterward.

There is a substantial research literature covering the connection between mental illness and families (Bland & Foster 2012; Bland, et al. 2021). At different times, families have been considered as causing or sustaining mental illness in a family member. At other times they have been recognised as carrying the burden of mental health care in the community, a burden that was formerly carried by the hospital. In more recent decades there has been a focus on families as carers, with the caring role of families recognised in policy documents, and even legislation. The mental health practice standards, in various forms, have stressed the importance of working closely with family caregivers to provide comprehensive patient and family care.

5.5.1 Impacts on the family

Family members interviewed for the Review described the impact that the mental illness of a loved one, and the subsequent hospitalisations, had on them and other family members. Three participants described how the mental illness of a parent deprived them of a mother's care when they were children; sometimes leaving them to a partner to care for them, or to placements in foster care or with extended family, all of which led to enduring trauma. As multiple familial participants said:

People need to know about things like that…Children had their parents ripped off them.

In losing our mother so early in our lives, we not only lost a role model for mothering and all things feminine, but we also never had the experience of living in a normal family unit with mother, father and children developing normal relationships.

The Review heard how the separation of patients and families was exacerbated when patients were admitted to Wolston Park Hospital from rural Queensland, making marital and family connection nearly impossible. The location of the hospital in South-East Queensland was described as a threat to family cohesion for those families living at a distance.

The Review heard of the disruption to ordinary family relationships where siblings adopted caregiving roles from a young age or were separated from each other as a parent struggled to cope once a partner had been hospitalised. Participants told about the level of shame that families experienced - shame that attached to the admission of a family member to Wolston Park Hospital, and a shame that discouraged families to maintain contact with family members while admitted. The participants shared how the location of the hospital, the stigma of mental illness, and the culture of the hospital conspired to isolate patients from their families and communities, and to impose the trauma of isolation and disruption on ordinary relationships.

5.5.2 Families as protection

The Review heard of the importance of family connections with the patient, and of how these connections provided a source of ongoing support and protection from abuse within the hospital. One sibling of a patient described the loving support of their mother who visited their brother every day in hospital for four years while he was a patient in Barrett Adolescent Centre. This participant described that their mother was welcomed and respected by hospital staff there:

[Back] then we'd go to the canteen, we'd have picnics, we'd sit there. It's a… it can be quite a beautiful place. It's got kangaroos, the golf course. So we made the best of the days, and my mother went every day, and she stayed all day while he was at the Barrett Centre. They were so obliging to my mum. They let us stay all day until she got back on the train to go home, and then she'd come back. And this went on for all of his adolescence.

This participant described that after turning 18, their brother was readmitted and spent months in McDonnell House on the older side of Wolston Park Hospital. The family continued to visit him as much as possible, but they described that they were not welcomed by staff. They were distressed at the care provided to their brother and complained when he was physically injured in an altercation with staff. The participant described an experience of visiting their brother in Pearce House, where he was admitted for environmental isolation, at a time when the men were being showered. They shared that the staff made an effort to ensure that they would be confronted by lines of naked men waiting for the shower. The described that they were fearful for their and their brother's safety:

The power and the control to have all those young men stand in a line and not even look at him, that nurse. It's extraordinary, isn't it? And to not even look at me.

A number of participants described the work of family members in reporting observed abuses and advocating for the discharge of patients from hospital.

> *[My brother] actually tried to get me out. And I did go to his house, and I was going to give it a go, but couldn't see anything in it…I ended up cutting myself and going back in…He did try and I never forgot him for that.*

The Review also heard from former patients who described that the absence of their families made them more vulnerable to mistreatment or abuse. Some of them have now enjoyed extensive family support over the decades since they left Wolston Park Hospital, which has allowed them to live safely in the community despite debilitating levels of trauma.

In summary, participants shared that, in their experience, the vulnerability of patients was exacerbated by an absence of family. But for those patients whose families were present, they experienced families as being supportive of patient welfare and protective of patient safety. Family members of patients in Wolston Park Hospital also described that they experienced their own difficulties in maintaining family relationships while their loved ones were admitted.

5.6 Supportive individuals made a difference

A recurring theme among the participants of the Review was the way individual staff were able to make a big difference in the lives of patients or family. Obviously, there were individuals described in Chapter 5.4 as inflicting abuses, but there were also staff who were identified as caring. These staff were people who intervened and stood up to the system in the pursuit of justice. These staff were singled out within participant's stories as providing a powerful hope-giving moment amidst their difficult experiences in Wolston Park Hospital. There were nurses, doctors, social workers, occupational therapists and psychologists in this list of staff who were prepared to champion individual patients.

The Review heard from one participant:

> *There were some villains in terms of staff at Wolston Park, but there were also some heroes and heroines. The social worker who was tasked to assist my brother to leave. He was certainly a hero… [My brother] met this wonderful occupational therapist and she became a champion for him…and he had a nurse who was a champion for him, who helped him to write poetry again, because they weren't allowed pens, notebooks, nothing.*

A former patient spoke of the power of a junior medical officer standing up for their patient:

> *And thank God [the doctor] was involved in this or I wouldn't be here now. […] he did the one thing that no one ever never ever seen anyone do. He went to Wolston Park that morning, found his patient in a pool of blood in Osler House and called the police. He didn't call the administration, which [was] unheard of.*

Another former patient shared a story about an occupational therapist who came to Osler House:

> *But the OT [occupational therapist] who came to Osler, she was only tiny, but she was fucking amazing. Instead of afternoon tea being the trolley brought up and giving you a paper cup, she took us into the OT's room and made a mini coffee shop.*

One participant, facing indefinite admission once they reached adulthood, describes leaving Wolston Park Hospital for the last time as an 'escape'. A nurse who had been good to them just let them out. They left and never returned.

Another former patient shared a similar story, attributing their escape from Wolston Park Hospital to the actions of a nurse:

> *A nurse, a lovely nurse. She got me out of there. I probably owe my life to that nurse…She put her job on the line to get me out of there. She knew what was happening. She talked to me privately and said, "I'm getting you out of here". And I went and lived with her [and her partner]. She got demoted over that. But she did it and got me out.*

Individual medical staff and psychologists were identified by multiple participants as being helpful. One participant remembers a psychologist who was very helpful to their recovery:

> *If I only had [this psychologist], I would have been out of there and had a job and a life. He was that good and he knew I was different from all the others sitting on the floor in the circle.*

Another participant describes the power of a nurse's care at a time of crisis:

> *There was one nurse at Barrett [Adolescent Centre] that actually helped to inspire, who was quite compassionate…She was very early in her career when I met her.*

They described a moment of panic on the first day of their admission where they struggled in a seclusion room:

> *I was overwhelmed. I was crying and everything and she just held me. And I know that's not something they normally do, but it was really helpful at the time. She was always really quite supportive, really gentle, really approachable.*

The Review heard from one former nurse of the courage of an occupational therapist who organised an outing for the patients that resembled a scene from *One Flew Over the Cuckoo's Nest* (1975):

> *There as an OT who came to take some of the Ellerton House patients out in a minivan and it was a wonderful story. I helped her take all the people out down the ramp and load them up…there was a clothes room there and we put them in the van, and [she] just drove*

them out the grounds…she just said "I'm taking them for a drive for the day so they can get the hell out of there".

The Review heard from a Brisbane religious leader who worked with Wilson Youth Hospital. They described the personal contribution of the Patient's Friend in protecting individual young women who had been transferred to Wolston Park Hospital. The Patient's Friend was a role established by legislation to provide individual and independent advocacy for patients at Wolston Park Hospital. This participant and the Patient's Friend worked discretely together to ensure the young women would be discharged into community care rather than face long-term placement at Wolston Park Hospital. The Patient's Friend was mentioned by several of the participants as a very helpful person.

This religious leader acted as a point of connection between the children coming through the child protection system, Wolston Park Hospital, and the broader community. They told of speaking to a psychiatrist who sent adolescent patients from Wilson Youth Hospital to Wolston Park Hospital:

He said, "I certify the young people and have them sent away. It's a hard job." I thought to myself, it would be an easy job if he didn't do it at all".

As Lead Reviewer, I am struck by these stories of individual staff and community members who were able to make a powerful human connection with patients in Wolston Park Hospital. At one level perhaps they were simply doing their jobs, but what they did was experienced by former patients as life affirming and hope giving. These actions created memories of compassion. At times the staff were described as acting in defiance of the existing culture or rules, and the power of that action was the greater for having a positive impact on patients. It is this recognition of the ability of individual workers to make a difference for people in distress which must continue to be central to the way we teach young mental health workers about their work. Individuals can make a difference. You can make a difference. It is not just about policy, systems and professional training. It is the human qualities that mental health workers bring to their work that can make a difference and be truly helpful for enabling vulnerable and mentally unwell patients.

5.7 Positive levers for change

5.7.1 The Nurses Training School

The Nurses Training School was established at Wolston Park Hospital in the 1960s. Before that time, nursing staff training was described as being limited to referring professionals to the 'Red Book'—an historical manual, bound in red cloth, of standardised clinical activities that covered basic mental health nursing care (Finnane 2008)—and on-the-job training from the more experienced staff. The reliance on the Red Book was described by one participant as perpetuating the custodial elements of the *Mental Hygiene Act 1938 (Qld)* rather than the therapeutic approaches to patient care that were emerging in the 1960s.

All the former staff that spoke to the Review who had commenced or completed their training in the Nurses Training School spoke very positively of the educators at the school and their capacity to support students to make nursing a professional career. The Review heard from six former student nurses. The training was delivered to students in six-week blocks alternating with placement in wards in the hospital. General trained nurses could get a specialist mental health certificate after 18 months of training. For those who took mental health nursing as a primary qualification, the course was for three years.

Speaking of the way the education staff were able to protect students at the Nurses Training School, one former student said:

> *The Nursing School was a place where you could go to tell some kind of truth about what you were seeing, what you were visiting in each ward. I can remember saying to [the Nurse Educator] I can't work in Ellerton House. I can't do it, [...], what I'm doing, what I'm being told to do. And she got me out of there.*

Another former student nurse described the support they received from the Nurses Training School as follows:

> *I always had support; always knew I could go to the School of Nursing. [The Nurse Educator] was just amazing and she would give us skills to cope, and she would then go and do spot checks without anyone knowing. We documented things with her, and she kept a good full record. But we always hunted out, that's what my mother said, hunt out someone who has been trained and use them as a mentor in the ward.*

As well as support from education staff, the former students described that forming supportive relationships with other students helped them cope with the resistance they experienced from some of the older staff who feared change:

> *There was a group of us that wanted to make a change…And we all just get together and tried to have a bit of support with each other. And say, "how can we make some changes", and we worked in with the School around this.*

5.7.2 Clinical Studies Unit

The Clinical Studies Unit was opened in 1987 as a 26-bed inpatient unit within McDonnell House and has hosted a highly respected research program since then. It has been a national leader in the field and has strong international partnerships. The research publication record for the Unit is attached in *Appendix 3*. Some former patients stated that they were subject to 'medical experimentation' and forced to take drugs they did not want or that it felt at times as if a clinician was testing out drugs in an experimental way. As Lead Reviewer, it is not for me to determine the substance of these statements. It is possible that clinicians needed to make changes to medication as drugs that had been tried and proven unacceptable.

The Review was told that once the Clinical Studies Unit was established, every effort was made to obtain informed consent for any patient participation in drug trials. Working with patients to obtain informed consent, even for those patients who are under treatment orders, is an important aspect of mental health research.

5.7.3 Project 300

Project 300, which commenced in 1995, was an ambitious program to prepare and discharge some 300 patients from Queensland mental health hospitals to community-based accommodation. Many of the Queensland patients supported by this program were residing at Wolston Park Hospital. The project was able to engage a whole of government approach to provide the range of supports and services, particularly housing, that would enable long stay mental health patients to move into community-based living alternatives. The project carried a substantial research component to evaluate the transition to community.

The Review heard from nursing, medical and social work contributors to the Project and they spoke proudly of the achievement of significantly downsizing the patient population by over 400 in 1995, to a point where Wolston Park Hospital was able to close in 2000. Project 300 was described as gaining significant opposition from some staff who realised that the closure of Wolston Park Hospital would mean a loss of their employment. The complex nature of the staff culture at this time is revealed in the following quote:

> *I think a lot of the staff had no real interest in discharging patients because they saw it as a threat to their job...And a lot of people had created lives around their jobs, you know, a lot of husbands and wives that worked there, boyfriends and girlfriends...but it was quite a test for the whole team. There was a lot of people married to each other and divorced from each other and had different relationships with each other. It was like a joint dysfunctional family...*

5.7.4 The significant changes in the 1990s

In the 1990s, the new senior clinical staff employed multiple change management strategies to drive developments in the clinical models at Wolston Park Hospital.

One of the former staff participants told the Review that the following documents were key to guiding positive change in mental healthcare in Queensland during the 1990s:

- Outcomes in Public Policy Institutional Reform and Mental Health: A case studying building better cities (Greenhill & Stewart.1995),
- 10-year Mental Health Strategy for Queensland (The State of Queensland, Queensland Health.1996), and
- Mental Health Plan (The State of Queensland, Queensland Health. 1994).

They explained:

> *We subdivided cohorts into you, know, pure diagnosis, extended rehab, you know. So we divided in to those programs and then reallocated, reassigned the hospital that way and then we had, we started measuring the outcomes...measuring the activity in the ward and the impact it was having on key...clinical indicators...We were constantly moving people, really, staff and patients and we did that understanding that it could be disconcerting but also understanding that it broke up the status quo.*

The regionalisation of health services throughout Queensland brought additional impetus for change. The regional services were required to manage their own patients and there was no longer an option to send the difficult patients elsewhere, including Wolston Park Hospital. Wolston Park Hospital came under the management of Ipswich and West Moreton Health Services in the 1990s and with this change came new Human Resources policies that provided a consistent and transparent approach to hiring appropriate staff. The workforce had to be downsized at the same time, given the planned reduction in the patient population. Wolston Park Hospital invested in external consultants to help staff members transition to new employment opportunities, or to accept redundancies.

A key change management strategy was to seek help from outside the hospital:

This included partnering with universities to build change communication strategies, establishing clinical measurement and benchmarking to understand service needs, minimising where possible disruptions for patients, policy reform, implementing performance appraisal, and promoting professional development…The administration started to look closely at patient complaints and tried to develop better relationships with families, to better support discharge and community-based care.

The document supplied to the Review about the change management process (Greenhill & Stewart 1995) shows a determined level of leadership among those managing the hospital at the time. Greenhill & Stewart (1995) observed that despite strong union opposition and constant personal threats, the leadership team managed the downsizing quickly and effectively. A small number of additional rehabilitation units for people experiencing delayed discharge were established on site to care for a group of patients but nearly all patients were placed in the community, in aged care facilities, with families or in other forms of accommodation. The Review was told that the Head Office of Psychiatric Services, Queensland Health was not always supportive of the hospital leadership team, and there were a number of visits from politicians concerned about the welfare of both patients and staff who were impacted by these changes.

In summary, the establishment of education and research functions, alongside the provision of the more contemporary, patient-focused mental health services, initiated a shift in operations at Wolston Park Hospital. The participants who were former students at the Nurses Training School described a program of education which fostered their identities as professional nurses rather than custodians of the mentally unwell. The Clinical Studies Unit aimed to modernise and legitimise treatment and medication provision and established a program of continuing education for its staff. Many participants who spoke to the Review expressed shock that custodial models of care were still used in wards outside of the Barrett Centre well into the 1990s. They noted that within the Barrett Centre there were programs and activities which supported recovery over confinement.

A wave of reforms in the 1990s—including Project 300—initiated the long process of further de-institutionalising Wolston Park Hospital. Participants who were staff in the 1990s described an effective change process that put patient care first and resisted opposition from within and outside of Wolston Park Hospital. The Review acknowledges the very special work undertaken in that last decade to effect systems change and to close Wolston Park Hospital.

5.8 Conclusion

When reflecting on the 66 interviews I witnessed as Lead Reviewer, I conclude that the Review process provided the opportunity for voices to be heard respectfully in a safe place. For some, it was a chance to confront very painful experiences and perhaps for these dark and shameful memories to be heard, for their past to be re-witnessed. The Review heard from a very small number of participants who had been patients or residents at Wolston Park Hospital. My hope is that the experiences of the majority of patients and families of Wolston Park Hospital were more positive than those of the few who shared their story with the Review. I believe that the Review has helped the former patients, and their families and carers, who contributed, to draw a line under their experience.

As one participant told me:

You can't go back and undo the harm but I think you can show them, you can acknowledge that this happened. You can say sorry which you rarely do in a legal

situation. You can say we've learned from that and the suffering you went through. These are things we've done so that someone else hasn't got to go through or some family doesn't have to go through what you've gone through.

6 Emerging themes

This Chapter describes the emerging themes which I have identified from the stories heard by the Review and the documents provided for my consideration as Lead Reviewer. It details my observations and reflections on what was shared and how these themes can be relevant in today's health system and institutional settings.

6.1 Vulnerability and power

The Royal Commission into Institutional Child Sexual Abuse (2017), subsequent reviews within the Salvation Army (2018) and the Marist Brothers (2019) communities, and the Aged Care Royal Commission (2021) present a simple analysis of the causes of abuse in institutional settings. They conclude that abuse happens because it can. Whenever there are vulnerable individuals and powerful carers, there is the potential for abuse. To prevent abuse there must be strong accountability and safeguards that ensure abusers are identified and held accountable through criminal, professional and organisational justice processes. There must be mechanisms for complaint, and for people to feel safe to report abuse, knowing that their complaints will be dealt with quickly and without fear of retribution. The stories shared by participants of this Review indicate that there must be a culture of quality, safety and patient-centred care in our health system and institutions. As the previously cited reviews of residential care have indicated, this involves having:

- An appropriate complaints mechanism, including transparency around how complaints are assessed and addressed, with a documented report back to the complainant.
- A clinical governance capability that creates accountability among clinicians at a particular facility and includes a known escalation pathway for patients, family members and staff members to raise issues.
- An empathetic patient-focused approach to supporting the rights of individuals to receive safe and quality care that aligns with their care goals and does not 'other' people with mental illness.

The stories that the Review heard certainly describe the vulnerability of the individuals, and the relative power of potential abusers during the Review Period. The stories describe the absence of effective complaint procedures and accountability within Wolston Park Hospital. The Review was told that abusive staff operated without fear of censure. A further dimension of the abuse described is the way that the patients felt they were treated as less than human via a process of 'othering'.

A family member expressed this process of 'othering' like this:

> *When we look at the way the most vulnerable are treated in our society, that tells us who we really are. I think that one of the things that went wrong in the past was that the humanity of those vulnerable people who found themselves in Wolston Park was diminished, denied and overlooked. They were the mad and the bad, beyond the pale. They had no one to fight for them and could therefore be treated in the most awful ways imaginable.*

A former mental health advocate who participated in the Review argued strongly that accountability of mental health services could only be guaranteed by having any review process, or complaint management, located outside the Queensland Health framework. They argued that there needed to be a judicial process to avoid having psychiatrists investigating other psychiatrists:

My observation coming out of talking to the women [who were former patients] was the absolute importance of making sure your safeguards and your human rights framework around the mental health system is tight, is usable, and people can actually access it.

In the current context, the abuse of vulnerable patients in mental health systems may be less likely to happen for a number of reasons, including:

Legislative protections	• The implementation of the *Human Rights Act 2019 (Qld)* and its associated Queensland Government Commission provides safeguards for human rights in public sector actions and decision making. • The *Mental Health Act 2016 (Qld)* and the *National Carer Recognition Act 2010 (Cth)* have legislated improvements in the protection of patient and family rights, including the promotion of least restrictive care and care in the community. • The *Mental Health Act 2016 (Qld)* provides for the transfer and management of patients from a place of custody to an inpatient Authorised Mental Health Service, with an emphasis on equivalence of care and alignment with national and international professional standards. • ECT is a regulated treatment under the *Mental Health Act 2016 (Qld)* and now requires patient involvement in decision making. • There are a number of legislative protections and internal and external oversight groups to manage and respond to concerns or complaints from patients and families within the mental health system.

Improved clinical practice	• The efficacy and application of medications and ECT as evidence based and therapeutic treatments has improved since the conclusion of the Review Period. Similarly, the advancement in the quality and safety of mental health medications has seen improvements in the monitoring and management of medication prescribing and potential side effects. • In inpatient settings there are more sophisticated systems to monitor the use of PRN medication, restraint, or seclusion. • There may be greater family involvement in patient care, which can provide an additional protection for patients. • The greater diversity of staff and roles in the multidisciplinary team means, perhaps, that complementary perspectives on treatment can be offered to ensure more comprehensive care and less reliance on the power of individual practitioners to determine treatment. • The implementation of National Standards and changes to quality and safety and clinical governance requirements for residential and institutional care.

The abusive dynamic that was described in some wards of Wolston Park Hospital throughout the Review Period is still relevant to any situation where power and vulnerability co-exist without the checks and balances that ensure safety. We have seen that dynamic operate in aged care settings and potentially in detention centres for refugees, youth detention centres, foster care settings and child-care centres. Many of the participants argued strongly that vulnerable children should never be kept in institutional settings with adults.

The issue for policy makers and service providers becomes not just carefully choosing safe staff or translating current policies into practice, but embedding processes that ensure the accountability of staff, encourage external scrutiny and facilitate the resolution of consumer concerns.

6.2 The enduring power of trauma and the opportunity to heal

The Review heard that the participants who were placed inappropriately at Wolston Park Hospital as children and young people had experienced major trauma before their admissions. Some described being sexually abused by family. Others had been placed there by family who simply couldn't cope with epilepsy or other physical disability. They described that the trauma they had already experienced as children was compounded by their experiences at Wolston Park Hospital. The other patients with severe mental health symptoms described that they were cared for in a containing environment where the medications and treatments were experienced as invasive. Having a severe mental illness is in itself traumatic and can be made worse when the treatment environment is seen as punitive. Being placed in seclusion was described by one participant as:

> *[an] illicit abuse of solitary confinement.*

Some of the family members who spoke to the Review described their own trauma, a deep sense of loss and of shame and guilt, about their inability to protect family members from the illness and the treatments they endured.

The trauma endures, touching every aspect of the individual's life. What was described within the wards of Wolston Park Hospital decades ago is still powerfully present in the lives of participants. So many of the participants who spoke with the Review suffer enduring distress associated with their experiences at Wolston Park Hospital. Some participants shared that they have difficulty accessing appropriate treatment and support for their ongoing mental health problems. These individuals are entitled to access services that are sensitive to dealing with trauma as part of an ongoing program of treatment and support. The mental health system and the community in general has a responsibility to support individuals on a recovery journey. We have seen how the trauma of an individual affects the lives of family and carers. It is experienced within a family context. Recovery happens through that same context. Supporting family is central to comprehensive care.

6.2.1 Trauma-informed approach

I have been careful to outline the trauma-informed approach that was applied in the processes of the Review (see *Appendix 2*). I was fortunate in this process in having the skilled staff, the resources and the time to apply a trauma-informed approach. The Review received solid feedback from participants that their participation in the Review has been an important part of their recovery journey. The Review worked to build relationships of trust with those wanting to speak to us so that revisiting their traumatic experiences would be contained. The Review showed that, with the right supports, the difficult conversations about past trauma can be revisited and re-witnessed.

6.3 Systemic issues

Both historical reports and the stories told to the Review have indicated that many people were admitted to Wolston Park Hospital through the decades because of the lack of alternative care available. The Review heard of how systems failed to provide appropriate care for some of the more vulnerable cohorts in Wolston Park Hospital:

People with disability	The Review heard stories of patients with profound physical or intellectual disabilities, epilepsy, degenerative neurological disorders and acquired brain injuries being institutionalised, sometimes for the remainder of their lives, within Wolston Park Hospital. These cohorts were in scope of the health services provided at Wolston Park Hospital within the Review Period, likely a holdover of the historical nature of the facility as a place of asylum. At times during the Review Period there was a lack of state-provided specialist care and residential options for these cohorts. The lack of specialist care for people disabled by epilepsy or neurological disorders may have made for inappropriate admissions. It is noted that from the 1960s, children with severe intellectual disability were cared for in a separate system and facility, though participants did describe living with intellectually disabled children (perhaps with a dual diagnosis) at Wolston Park Hospital as late as the 1980s. Participants who were former patients described witnessing patients with disability be neglected, ignored or mistreated during the Review Period.
Children in care	The most glaring example of a systemic issue that emerged from the interviews was the seeming inability of the child protection system to care for children with behavioural problems, and that their processing through hospital-based psychiatric wards and then Wolston Park Hospital was a placement of last resort during the during the Review Period up to the 1980s. The stories shared as part of this Review indicate that these placements served to medicalise a behavioural problem and expose the young people to a range of medical treatments—including medication, ECT, restraint and seclusion—that they did not need. The former wards of the State that spoke with the Review described experiencing neglect, mistreatment and abuse while admitted to Wolston Park Hospital. The stories shared as part of the Review also indicate that the mental health system became a place to contain the failures of the child protection system during the 1950s through to the 1980s. The State of Queensland recognised these failures via a statement of apology in 2010.
People in custody	The former patients who participated, particularly those who were children and minors during their time at Wolston Park, described that being held or treated in the same spaces as adult prisoners and violent offenders under involuntary orders engendered a near constant sense of fear and danger. Many of them described carrying that fear to this day. Further, the sudden influx of criminal patients from Boggo Road Gaol in the 1960s was also described as changing the capacity of the wards to provide less restrictive treatments and resulted in more punitive measures to control all patients. The issue is not that individuals from the justice system were transferred to receive mental health treatment and care, it is in how Wolston Park Hospital managed this cohort, their accommodation in the facility and their interactions with other vulnerable patients.
People with dementia	There were also wards at Wolston Park Hospital during the Review Period that housed large numbers of people with psychogeriatric illnesses and dementia. These people are now able to be cared for within specialist dementia aged care-services. The stories shared with the Review describe excessive physical restraint

of patients with dementia, beyond what was a standard of care at the time, and an absence of dignity in how these people were cared for. These stories indicate how important specialist care is for older people with behaviours and psychological symptoms of dementia, and for Queensland's ageing population it continues to be an important health and social care capability.

6.4 Lessons for policy, practice and teaching

As set out in the Chapter 5.6, many of the former patients and their families were able to nominate key individuals who provided the right kind of help at the right time, and who provided hope that things would be better for them. It seems that what was most valued by patients was the humanity of staff who behaved in a respectful way toward patients. It was the individual's compassion and kindness that was meaningful and hope-giving. Similarly, the student nurses described how they appreciated the personal care they received from the staff of the Nurses Training School. These helpful people were remembered and named by participants. They were people, not just professional roles.

So much of the discourse in mental health and other human services is about:

- competencies and policy,
- getting systems right,
- enabling human rights, and
- professional skills and knowledge.

Beyond these imperatives lies the need for workers to bring an intensely human approach to their work. I appreciate that this is difficult for workers to do all the time, but when it happens, there is the potential for life changing moments. In the training of the professions, there must be space to explore what it's like to be psychotic, be powerless, be poor, feel shame, or feel loved.

This is an argument to take seriously the nature of lived experience, and to struggle to understand the world of the other. The capacity to be truly human in our work does not replace the need for competence, knowledge, skills and policy. It doesn't devalue what we do, or what we know. It does however, privilege 'being' as a core part of our work. Who we are—and that includes our compassion, our curiosity, and our courage—matters to the people we work with. This is a truth that all those in the helping professions need to embrace in teaching students, in supervising staff and in leading teams.

6.5 Systems fail but families might get it right

One story from the Review carries a challenging message for mental health professionals. I was told about a young woman married to a First Nations man. He was away from home for extended periods with his work. The woman lived in a very remote part of the State. When she became very unwell, possibly with a post-partum psychosis, she needed intensive care. There were concerns about family violence.

When she was admitted to Wolston Park Hospital her marriage collapsed, and her husband re-partnered very quickly. She was in an acute care unit at Wolston Park Hospital – a single woman, victim of family violence, and with two young children to care for. The risk factors for the children are so obvious, yet there was no identification by social workers on the unit that the children were at risk and that a referral to the Department of Children's Services was urgently needed. Her husband's First Nations family quietly took care of the children. When she was discharged, she moved to northern New South Wales where there was a network of her husband's relatives who cared for the family. She eventually recovered and was able to give the children a secure home and a good education that has led to success in their adulthood.

This is a challenging story on many levels. As a social work educator, I am disappointed that the social workers in the unit did not realise the seriousness of the risks involved. I can also see that engaging the child protection system during the admission might well have had negative consequences for the children, as removal to foster or institutional care would have been considered. Yet the outcomes of a failure to act here are very positive. A good social worker may have considered the level of support available from the woman's own family and decided that it was ineffective. A better social worker might have assessed the level of support

available to the family from the husband's aunts and cousins and tried to engage that support. But such was the level of distrust among First Nations people in the light of the stolen generation practice that there would have been little chance of that kind of partnership happening. The best outcome was achieved because the system failed to see the need. This story is testament to the capacity of First Nations families to care for their own people. At a broader level, it affirms the importance of family in supporting and protecting family members struggling with the impact of mental illness.

7 Recommendations

In my role as Lead Reviewer, I was afforded the opportunity to provide recommendations to the Director-General, Queensland Health based on the outcomes of the Review. I have only two recommendations to make. The real value of this Review lies in the opportunity it gave participants to share their experience at Wolston Park Hospital, and for those stories and experiences to be heard. In the previous two chapters I have set out what I heard, and how I made sense of those stories.

An important part of concluding the Review process is that the voices of former patients and residents, and their families, should also be heard by the broader public. Participants provided information with a clear desire to have their stories made public. The Wolston Park Hospital closed twenty-five years ago, a sufficient time for an historical perspective to overtake any personal sensitivities that would suggest the lived experience of participants should not be openly reported. Some of the participants expressed a strong preference that their names to be included where they wrote directly of their or their loved one's experience (*Appendix 4*). Withholding their names was, for some, a further extension of their sense of being silenced by the Queensland Government. Such publication was not possible given the Terms of Reference which strictly protects the privacy of participants and have regard to privacy considerations relevant to non-participants.

I recommend that:

1.	The Report be published in its entirety.
2.	Queensland Health allows the publication of the names of participants in *Appendix 4 – Participant's Stories in Their Own Voices*, where this has been specifically requested by the participants.

8 References

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Appendix 1 - Terms of Reference, Wolston Park Review

Queensland Health

Wolston Park Review

Terms of reference

Review into Wolston Park

1. Professor Robert Bland AM is engaged as Lead Reviewer to conduct a review and prepare a report into the health services provided at Wolston Park Hospital (**Wolston Park**) (also known as the names listed in Annexure A) between 1 January 1950 and 31 December 2000 (**Relevant Period**) (the **Review**).
2. In conducting the Review, the Lead Reviewer may invite:
   a. former patients/residents to describe their experiences during the Relevant Period, concerning their treatment and experiences whilst at Wolston Park Hospital; and
   b. family members and/or carers of former patients/residents of Wolston Park to describe their experiences during the Relevant Period.
3. The Review is not designed or intended to:
   a. require or compel anyone to participate in the Review;
   b. determine liability nor the truth of any participants' experiences or stories;
   c. provide clinical assessment or care;
   d. pay, or recommend the payment of, compensation;
   e. judge participants or anyone mentioned by a participant, or to reach a conclusion about what might or might not have happened;
   f. in any way attempt to resolve differences of views; or
   g. allow participants to have legal representation when sharing their experiences.

Access by participants

4. The Lead Reviewer may invite eligible people to participate in the Review by providing written submissions or attend an in-person meeting.
5. For any in-person processes, the Lead Reviewer will:
   a. arrange for meetings to be held in locations and times that are reasonable and accessible for participants;

Wolston Park Review - Terms of reference

Queensland Government

b. arrange for participants to be assisted, if necessary or where available, for actual and reasonable transport costs in attending in-person processes (and other necessary costs in special circumstances), with all assistance to be determined at the discretion of the Lead Reviewer within specified parameters;
c. permit participants to be accompanied by up to two support people to in-person process (but not legal representation), noting that support people cannot speak on behalf of the participant without the permission of the Lead Reviewer; and
d. permit participants to bring to any in-person process any documentary material that assists them.

Environment, Confidentiality and Process

6. The Lead Reviewer will:
    a. arrange to hear a participant's experiences and stories where possible in a comfortable and private setting where participants can be confident of being heard in an appropriate manner;
    b. advise each participant that their participation in the Review is on the basis that what is said during an in-person process or submitted in writing will be treated confidentially and is not intended to be used in any other process outside the Review, without their consent, unless required or permitted by law; and
    c. listen in an appropriately trauma-informed, non-critical, non-judgmental, receptive and constructive manner.

Support to participants

7. The Lead Reviewer will:
    a. establish a support system that is appropriate to provide additional treatment, support or assistance to participants; and
    b. to the extent permissible within the bounds of the Terms of Reference, assist the participant to engage in the process in a trauma-informed way.

Administration and support

8. Department of Health will provide administrative support to the Lead Reviewer reasonably required for the Review to be completed effectively and efficiently.
9. Additional reviewers may be appointed if necessary.

Preparation of report

10. The Lead Reviewer will produce a report to the Department and may make recommendations including whether the report be made public:
    a. within 11 months from the date of their engagement (or as otherwise agreed by me), a draft report is to be provided to the Director-General, Department of Health, for consideration as to whether these Terms of Reference have been met by the report; and
    b. within 12 months/weeks from the date of their engagement (or as otherwise agreed by me) the final report is to be provided to me (noting that such report, or an executive summary of it, with any necessary redactions in compliance with law, may be released to participants or the public).
11. The scope of the report is to focus on systemic issues and thematic analysis during the Relevant Period, recognising, nevertheless that this will be informed by individual cases and there may be a need to make referrals to appropriate supports and provide access to information on relevant authorities in individual cases.
12. The report must de-identify personal details of participants in the Review.

Progress reports and updates

13. The Lead Reviewer is to notify the Director-General, Department of Health about the progress of the Review at regular intervals, as will be agreed following their appointment.
14. Any request for an extension of the due date for the reports is to be made in writing to the Director-General, Department of Health at least 7 days before the due date, with supporting reasons.

Department of Health contact

15. For any instructions or other assistance during the course of the Review, please contact: Deputy Director General, Strategy Policy & Reform

Media

16. The Lead Reviewer must not make any public statement in relation to the Review and if approached by a representative of the media, must refer the media representative to the Media Unit, Strategic Communications, Department of Health, on news@health.qld.gov.au and immediately contact the Department of Health Contact.

Appendix 2 - The Trauma-Informed Approach utilised in the Wolston Park Hospital Review

> *A program, organisation, or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatisation.*
>
> ***Substance Abuse and Mental Health Services Administration (SAMHSA), 2014, p9***

Introduction

This Appendix to the *Report into Experiences of Treatment and Care at Wolston Park Hospital, 1950 to 2000* details the Trauma-Informed Approach (TIA) used in the Wolston Park Hospital Review (the Review) and offers a reflection on the efficacy of this process. This Appendix explores the personal insights and critical reflections of the Review Team on the TIA and draws upon relevant experience and theory to provide the learnings from the application of a TIA in the context of the Review.

This Appendix is written from the perspective of the Review Team, and the Review would like to acknowledge that the perspectives shared here may not accurately reflect the experiences of all those who participated. The Review acknowledges the courage of all who participated in the Review and shared their knowledge and experience to improve systems and processes that actively resist re-traumatisation. The Review is conscious of not exploiting the interactions with participants within this Appendix and have attempted to avoid using specific examples of the TIA in practice at an individual level. This Appendix presents the process used in conducting the Review and provides observations on the value and importance of a TIA for future Governmental reviews and projects that may explore complex trauma.

The TIA used in the Review emphasised the design of processes which created safety and choice in participation, were validating and responsive to participants and which actively resisted re-traumatisation. This approach demonstrated multiple benefits, including the enrichment of the information gathered and feedback from participants that the process was a safe and positive experience.

Background

The Review was established in October 2024 to conduct a thematic analysis of health services, systemic issues and experiences at Wolston Park Hospital between the years of 1950 and 2000 (inclusive). Wolston Park Hospital, once the largest mental hospital in Australia, was a decommissioned mental health facility that operated at Wacol from 1865 until 2000 when it was closed.

The Review was established under a Terms of Reference which required the use of a TIA in listening to the voices of participants in the Review. Participants included former patients, residents and family members and carers of Wolston Park Hospital who had publicly identified experiences at the facility. Former staff and local historians were also interviewed to provide context, background and understanding to the patient and family experience. The Review was led by Professor Robert Bland AM and focused on listening to, but not determining the truth of, the experiences of participants.

The principles of a Trauma-Informed Approach

A TIA is a framework of practice which recognises and responds to the impacts of trauma on individuals. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides a widely recognised approach known as SAMHSA's Concept of Trauma and Guidelines for a Trauma-Informed Approach (SAMHSA, 2014). The Six Key Principles of TIA (SAMHSA 2014) are:

- Promoting **Safety** in physical settings and interpersonal interactions.
- Embedding **Trustworthiness and Transparency** in interactions.
- Valuing the contributions of **Peer Support** to those with lived experiences of trauma.
- Promoting **Collaboration and Mutuality** in interactions.
- Ensuring **Empowerment, Voice and Choice** in participation.
- Applying considerations for **Cultural, Historical and Gender Issues.**

What the Review did

Creating a Trauma-Informed Approach within the Review

The Review Team commenced the project with the knowledge that many of the participants may be living with complex post-traumatic stress disorders or mental ill health relating to their experiences of Wolston Park Hospital. As such, the Review fostered a team culture that prioritised a TIA as an integrated part of planning and decision making. The Review drew upon current research and resources such as *The Queensland Trauma Strategy 2024-2029* (Queensland Mental Health Commission 2024), the *Report of the Confidential Forum for Former In-Patients of Psychiatric Hospitals* in New Zealand (Mahoney et al. 2007) and the prior professional experience of the Review Team to establish a strategy for responding to trauma in the Review context.

Initially, the Review Team held workshops to discuss what constituted a TIA at a personal level and developed the values which underpinned the approach to conducting the Review. The Review made a commitment to actively avoid re-traumatisation of the participants in both the short and long term by ensuring an appropriate exit pathway from participation. The Review also considered the inherent power imbalance between participants and the Review Team. The Review Team was conscious that in sharing their experiences with the Review, participants would be relinquishing control of how their stories would be used and that they were reliant on strangers or authority figures to accurately represent their experiences. In acknowledging these imbalances, the Review endeavoured to create a process that valued lived experience, and which might contribute to personal healing for participants.

The key values that shaped the TIA and the broader Review process included:

- The centrality of lived experience of mental illness and care as a focus for the Review.
- The importance of listening and hearing.
- A recognition of the enduring impact of trauma and the ability to heal.

These values were considered alongside the Six Principles of TIA (SAMHSA 2014) to develop an internal procedure, or Model of Support, which prioritised relationship-based interactions with participants of the Review and formed the basis for developing the *Report into Experiences of Treatment and Care at Wolston Park Hospital, 1950 to 2000*.

The Model of Support informed the design the Review's communication strategy. This involved a four-step contact process of pre-engagement, consent, interview and debrief. Additional communications or one-to-one contact with participants were to occur as requested by the participant and to provide updates on progress. Each registered participant of the Review was allocated a primary contact within the Review Team to establish consistency within the four-step contact process. Participants with complex trauma were linked with a primary contact with a clinical background in responding to trauma.

The purpose of the pre-engagement stage was to build mutual trust and understanding between the Review and its participants. This stage was used to communicate the goals and processes of the Review with transparency, and to design an interview format which considered the individual safety, social and support requirements of participants. It was important to identify any existing support networks and providers that participants had in place so that the Review could broker non-government counselling support or referrals as requested. During the pre-engagement stage, the Review identified that an essential element to successfully implementing this TIA was investing sufficient time to establish and build reciprocal relationships between participants and the Review.

The second contact stage was designed to enable one-to-one discussions about the consent framework of the Review and to obtain the formal signing of participation consent. The Review acknowledged that participants may find the participation consent form and associated resources overwhelming and confusing. However, very few participants identified that they required a bespoke contact for consent and opted to discuss and sign at the time of the formal interview.

The third contact stage was the formal interview of the Review, where participants would share their lived experience of Wolston Park Hospital. The Review acknowledged that there was a risk that participants might experience a trauma-response in this stage of contact. The Review Team designed the interview format to mitigate this risk as much as possible. Consideration was given to the location of interviews, including ease-of-access and environment requirements that would contribute to a sense of safety during the interview This included having a quiet space for the interview, visible entry and exit points and ensuring the room had natural light. The gender and diversity of the interview panel was also considered alongside factors relating to the historical lived experiences of participants. For example, as Wolston Park Hospital was a Queensland Health facility, the Review Team chose not to wear any clothing or lanyards which identified them as Queensland Health employees to avoid a potential visual trigger. Participants were encouraged to have a support person with them at the interview to help them feel as comfortable as possible during the interview. The interview did not have a formal agenda outside of introductions and establishment of the interview duration (approximately one hour). Participants were empowered to share their stories and lived experiences in a manner that suited them and at their own pace. The interviews were also designed to be adaptive to the needs of the participants, with the Review team holding space to break when necessary or to conduct the interview over multiple sessions. At the close of each interview session, the Review panel shared with the participant what they took away from the participant's telling of their lived experience. This provided a personalised acknowledgement of the value of the participant's contribution to the process. Following the interview, the participant's primary contact accompanied them as they left the session and spent some time conducting an immediate de-brief to support emotional regulation for both the participant and their support person, as and if needed.

The final contact in the four-step process was designed to de-brief participants in the days or weeks following their interview. This contact was used to discuss how the interview experience was for participants and to identify if they required further access to non-government counselling support. The de-brief contact occurred depending on the participants preference or needs. Some participants wanted limited contact following the interview while others actively stayed in touch with their primary contact for a brief period after the interview. To ensure a safe 'step-down' process, the Review Team remained transparent with participants about the scope of their roles and the expected timeframes for completing the Review.

Outside of the four-step contact process, the Review and the primary contacts remained available to respond to the individual needs of participants and to facilitate support for trauma-responses amongst participants if and as they occurred. For some participants, this involved additional phone conversations or in-person meetings before or after their interview to identify needs or to simply have conversations about the processes or desired outcomes of the Review.

The Six Key Principles of TIA (SAMHSA 2014) and how they were considered within the four-step contact process are depicted in Figure 1.

1. Safety

Refers to safety in physical settings and interpersonal interactions.

Safety was considered in the:

- Limiting of contact with the Review to minimise re-traumatisation.
- Physical environment of the interview, including visibility of exits, natural light, and privacy.
- Ensuring appropriate supports were available to participants in a community-setting.

2. Trustworthiness & transparency

Operations and decisions are transparent, consistent, respectful and fair to build and maintain trust.

Trustworthiness and transparency were established through:

- Communication of the Review objectives, limitations, process, and potential outcomes.
- The sharing of personal values between participants and primary contacts.

3. Peer support

Refers to support from those with lived experiences of trauma.

The importance of peer support was applied by:

- Identifying and leveraging a participant's existing support networks.
- Encouraging participants to have a support person (e.g., family members, friend, carer or advocate) present at the interview.
- Providing connections to new support networks when requested.

4. Collaboration & mutuality

Includes partnering and leveling of power differences between and among clients and staff.

Collaboration and mutuality was encouraged by:

- Designing the format of each contact based on the needs of individual participants.
- Creating feedback loops between participants and the Review to acknowledge the value of the experiences that were shared.

5. Empowerment, voice & choice

Ensuring individuals' strengths and experiences are recognised and built upon.

Participants were empowered in participation by being:

- Reminded of the voluntary nature of participation.
- Encouraged to disclose their needs and to tell the Review if those needs weren't met.
- Given control of the interview to share their experiences in their own way.

6. Cultural, historical & gender issues

Considering moving beyond organisational cultural stereotypes and biases.

Potential issues relating to cultural backgrounds, personal histories and gender were considered through:

- Tailoring the interview panel appropriately.
- Encouraging conversations about these issues within the interview setting.
- Applying the awareness of these issues to how the Review team presented themselves.

Figure 3 - Principles of a TIA (SAMHSA, 2014) as applied within the Review

Internal application of the TIA

Just as the Review commenced the project with the awareness of enduring trauma amongst participants, the Review was also aware of the potential impacts of vicarious trauma on the Review Team. Vicarious trauma refers to the personal impacts of engaging with people with existing trauma and their experiences when combined with the sense of duty to provide support and honour their experiences (Pearlman & Caringi 2009). To mitigate vicarious trauma responses amongst the team, the Review implemented safeguards which adhered to the Principles of TIA (SAMHSA 2014), including:

- A three-hour workshop facilitated by an expert in vicarious trauma which provided tips for managing vicarious trauma responses.
- Voluntary participation in interviews from the project support team and balancing of interview commitments for primary contacts.
- Review Team de-briefs immediately following interviews to support the processing of information and identification of any immediate psychosocial requirements.
- Weekly recaps and reflections of interviews as a group, with individuals encouraged to share what they took from the participant's stories.
- Implementing external supervision and support for members of the Review Team.

Feedback received on the application of TIA

Participants were given the opportunity to provide feedback on their experience of participation via an online survey. Many participants also opted to provide feedback directly, either at the point of interview or via email. The response from participants was generally positive, with most acknowledging the personal difficulty of participating but having appreciation for how the process was conducted.

Of the 66 participants, 19 chose to provide feedback via the online survey. Of those, 84 per cent identified that they felt 'well supported' (the highest option) during the Review process and the remaining 16 per cent felt 'supported'. 63 per cent felt 'very prepared' prior to their interview, with the remaining identifying that they felt 'somewhat prepared' (27 per cent) or 'neither prepared nor unprepared' (10 per cent). 74 per cent were 'very satisfied' with their interview experience (the remaining 26 per cent were 'satisfied), and 84 per cent felt that they were able to fully share their story with the Review with the remaining 16 per cent identifying that they felt they did not share quite all of their story. None of the participants who responded to the survey provided negative feedback on their experience with the Review.

One participant anonymously shared the following feedback:

> *I was so impressed by the process from first contact to the last contact. I was far more overwhelmed than I expected but the team were very respectful and supportive making it the very best process it could be. The knowledge was there to interview but also regarding impact on people involved and what was required for emotional and psychological safety. It was a very well thought through process and a credit to the team.*

Observations and learnings from the Trauma-Informed Approach

The following section describes the observations and learnings of the Review Team that were relevant to the implementation of the TIA within the Review.

Honouring the principles of a Trauma-Informed Approach

From the outset, the Review Team were committed to honouring and adhering to the Six Principles of TIA (SAMHSA) and ensuring that safety and empowerment were central to the Review process. Emphasis was placed on people participating in this process in the way that they wanted to and allowing the Review Team and processes to adapt where possible. The Review was transparent in how the process was conducted, ensuring that the Review communicated the values of the Review and the steps being taken to provide safety for the participants. The Review Team were candid in sharing their views in the interviews and created space for genuine emotions to be shared freely between the participants and the Review Team. These actions contributed to the establishment of trust and reciprocal relationships between participants and the Review Team members.

Relationship was key

The Review Team identified that prioritising connection and relationships created a safety and transparency that held participants and the Review Team through challenging times. Throughout the pre-engagement phase and beyond, the primary contacts and members of the interview panel were transparent in sharing information about themselves, their jobs and their values. This was done naturally and without pretence and contributed to a mutuality in interactions rather than contribute to the imbalance of power between participants and the Review.

The Review Team maintained a willingness to be confronted and challenged by the interactions with participants and the stories being told. The Review Team acknowledged that complex emotional reactions could arise throughout the process and that the Review could experience bouts of hostility from participants. It was important for the Review Team to maintain awareness of the feelings of mistrust towards Queensland Health and Government institutions that many participants had expressed. The team responded to challenges or confrontation as they occurred and, leaning on the Six Principles of TIA (SAMHSA 2014), attempted to respond with respect, kindness and open communication.

Availability of resources to implement and adapt

The Review was fortunate to have both the labour and financial resources to implement a TIA. Despite a heavy workload, the Review had sufficient resources and team members to successfully manage the impacts of the Review process on participants. In the planning stage, the Review anticipated that a level of traumatisation and/or stress amongst participants was highly likely and made budget considerations to enable the brokerage of necessary supports. While this was required in only a small number of cases, the Review was able to enhance existing community-based care services such as counselling, peer support, psychology services and respite for those who asked for it. The Review Team made sure to minimise contact with participants during times of identified distress and obtained consent to communicate with care providers to confirm that support needs were being met. In these instances, the participants re-initiated contact with the Review when they were ready, either to share additional information relating to their experiences or to provide feedback to the Review.

It was also important for the Review to maintain adaptability in an administrative sense. During the expedited interview schedule, the Review was required to adapt to the arising needs of participants in their ability to attend interviews. This meant not committing to venues too far in advance to allow for weekly assessment of

where the Review would be. The adaptive approach of the Review also included an intensive, but short, travel period to accommodate both the availability and psychosocial needs of participants.

Balancing the tension between timeframes and a Trauma-Informed Approach

The limited time frames within the Review and a 10-week interview schedule meant the Review Team needed to move quickly through the four-step contact process. The Review Team prioritised creating a safe space for robust communication, which allowed them to explore and challenge each other when deadlines competed with the need to slow down and prioritise the TIA.

The Review Team upheld the commitment to participants in providing them the time they needed to participate in a safe and open manner. This meant that there were no time pressures to conversations applied to participants outside the formal interview. Instead, the Review Team allowed participants to speak openly and freely and leveraged the other members of the team for support in completing other tasks relevant to the progressing the Review.

The TIA also took place within the team setting, and the Review emphasised the importance of slowing down to maintain a positive team culture throughout the process. To deliver the TIA effectively, the Review Team maintained awareness of the risks and symptoms of vicarious trauma. Supporting the Review Team's psychosocial wellbeing was a priority, and staff were encouraged to attend to their own needs in responding to vicarious trauma. This was observed as essential to staying present for participants and ensuring the project was completed on time.

Queensland Health as host of the Review – a challenge and an opportunity

The Review was hosted by Queensland Health, whom many of those calling for the Review held responsible for ongoing trauma relating to Wolston Park Hospital. Some participants expressed their fear and mistrust about meeting with employees from Queensland Health. Based on important feedback, the Review learned to be mindful of dressing in an independent way in their meetings with participants.

The structure of the Review Team had two independent consultant roles and four Queensland Health employees. This diversity between independent and government team members created an unexpected opportunity for healing and connection. The Lead Reviewer emphasised a collaborative approach between his independent role and the role of the Program Manager, Queensland Health and ensured that they both attended most, if not all, interviews with participants. Some participants provided feedback about the importance of being listened to and validated by Queensland Health officers and shared that seeing them demonstrate their commitment and passion for safer health care systems was a powerful gesture of respect.

The Terms of Reference of this Review, which focussed on listening and experience, enabled the Review to be conducted without agenda or judgement. The perceived limitation of not having an authority to determine truth of stories or to draw conclusions about what may have occurred at Wolston Park Hospital was an enabler in disguise. It allowed the Lead Reviewer and Review Team to foster an environment which empowered participants to share their experience without having to worry about being prosecuted about the details or how others might have experienced the same event.

Awareness of being heard by a person in a position of authority

Many participants of the process conducted in New Zealand by Mahony et al. (2007) reported that they experienced healing from being heard by people in positions of authority who had access to Government. Similarly, participants of this Review provided feedback that the Lead Reviewer's independence from the Government and his ability speak to both them and governmental authorities without political agenda was an important part of gaining their trust and feeling validated in speaking with the Review. As stated in the previous section, they also fed back that they appreciated that the representatives from Queensland Health were able

to demonstrate a commitment to their participation and ensuring that the lessons learned from their experiences could be used to create change in the mental health system.

Implications for similar processes and projects

The TIA undertaken within this Review did not adhere to a defined framework or rigid approach and instead used a principles-based approach that highlighted individual's experience versus a defined clinical or policy responses.

It was important for the Review to embed an agile approach to responding to the needs of participants because each participant's experience was unique. In conducting similar processes or projects, it would be useful for governmental teams to have a similarly adaptive and responsive approach with a focus on relationship management.

Acknowledging the limitations of a Trauma-Informed Approach

Even with the use of a TIA in this Review, it was evident that some participants experienced impacts on their wellbeing and mental health. Some participants reported that from the moment the Review was announced it had impacted them adversely. As a process and a Team, it was acknowledged that the Review had no ability to control how the participants and the public would feel and react to the Review. However, the Review Team were steadfast that the implementation of a genuine TIA could influence the experiences of participants and provide positive outcomes in participation.

The Review Team were grateful that, overall, those who felt most impacted by enduring complex trauma provided positive feedback about participating in the Review. The Review received important anecdotal feedback that the Review provided a process that offered some level of healing or comfort for participants.

Conclusion

This paper emphasises the need for an adaptable TIA to be applied when conducting engagement projects and processes with members of the public living with complex or enduring trauma. The Review Team hopes that the TIA applied within this Review allowed the process to be of some benefit to individuals and contributed to increased well-being for participants. The key factors in creating a TIA for the Review were the awareness of unequal power relationships, the validation of an individual's choice to participate, and the establishment of transparent and reciprocal relationships with participants. The Review endeavoured to use the TIA as a response to invisibility and silencing, which is a significant trauma for people who have experienced personalised and systemic abuse and harm. The Review Team hopes that this model may add to future knowledge to create systems and processes that actively resist re-traumatisation.

References

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Appendix 3 - Publication record of research at the Clinical Studies Unit, Wolston Park Hospital

Provided to the Wolston Park Hospital Review by The Park Centre for Mental Health Treatment, Learning and Education, West Moreton Hospital and Health Service.

Year	Study and Reference	Type of study	Partners	Involves direct contact with patients at CSU and/or WPH
1987	Whiteford, H. A., & Price, J. (1987). Genetic counselling and psychiatric illness. Aust Fam Physician, 16(7), 958, 961-954.	Review		No
1988	McGrath, J. (1989). Psychiatry, Molecular Genetics and Ethics. The New Discoveries and the New Issues. Australian and New Zealand Journal of Psychiatry, 23, 67-72.	Review		No
1989	McGrath, J. (1989). A Survey of Deliberate Self Poisoning. Medical Journal of Australia, 150, 317-324.	Chart review quality study	Princess Alexandra Hospital	No
1989	McGrath, J., Collins, J., & Nord, V. (1989). People with Schizophrenia, their families and the Researchers. Balance, 1, 13-21.	review		No
1989	Stedman, T., & Whiteford, H. (1989). L-Tryptophan is natural perhaps even rational but is it effective? Australian Prescriber, 12(1), 3-4.	Review		No
1989	Whiteford, H. A., & Peabody, C. A. (1989). The differential diagnosis of negative symptoms in chronic schizophrenia. Australian and New Zealand Journal of Psychiatry, 23(4), 491-496.	Review	Stanford University	No
1990	McGrath, J. J. (1990). Ordering Thoughts on Thought Disorder. Schizophrenia Research, 3(73).	Review		No
1990	Stedman, T., & Whiteford, H. (1990). Tryptophan: in reply. Australian Prescriber, 23(2), 29.	Review		No
1990	Stedman, T. J., & Whiteford, H. A. (1990). Dopaminergic super sensitivity and vomiting among schizophrenic patients. Acta Psychiatrica Scandinavica, 81(1), 94-95.	Clinical observational study		Yes

Year	Study and Reference	Type of study	Partners	Involves direct contact with patients at CSU and/or WPH
1991	Levinson, D. F., & Mowry, B. J. (1991). Defining the schizophrenia spectrum: issues for genetic linkage studies. Schizophrenia Bulletin, 17(3), 491-514.	Review	Medical College of Pennsylvania	No
1991	McGrath, J. (1991). Ordering thoughts on thought disorder [see comments]. British Journal of Psychiatry, 158, 307-316.	review		No
1991	Stedman, T., Whiteford, H., Eyles, D., Welham, J., & Pond, S. (1991). Effects of nifedipine on psychosis and tardive dyskinesia in schizophrenic patients. Journal of Clinical Psychopharmacology, 11(1), 43-47.	Clinical trial	University of Queensland, Princess Alexandra Hospital	Yes
1991	Subramanyam, B., Pond, S., Eyles, D., Whiteford, H., Fouda, H., & Castagnoli, N. J. (1991). Identification of potentially neurotoxic pyridinium metabolite in the urine of schizophrenic patients treated with haloperidol. Biochemical and Biophysical Research Communications, 181(2), 573-578.	Clinical observational study	University of Queensland, Princess Alexandra Hospital	Yes
1992	Eyles, D., & Pond, S. (1992). Stereoselective reduction of haloperidol in human tissues. Biochemical Pharmacology, 44, 867-871.	Clinical observational study		Yes
1992	Eyles, D., Whiteford, H., Stedman, T., & Pond, S. (1992). Determination of haloperidol and reduced haloperidol in the plasma and blood of patients on depot haloperidol. Psychopharmacology, 106(2), 268-274.	Clinical observational study	University of Queensland, Princess Alexandra Hospital	Yes
1992	Whiteford, H. (1992). Future directions for mental health services in Australia. Australian Journal of Public Health, 16, 350-353.	Review		No
1992	Whiteford, H. A., Stedman, T. J., Welham, J., Csernansky, J. G., & Pond, S. M. (1992). Placebo-controlled, double-blind study of the effects of proglumide in the treatment of schizophrenia. Journal of Clinical Psychopharmacology, 12(5), 337-340.	Clinical trial	University of Queensland, Princess Alexandra Hospital. Washington University School of Medicine	Yes
1993	Mowry, B. J., & Levinson, D. F. (1993). Genetic linkage and schizophrenia: methods, recent findings and future directions. Aust N Z J Psychiatry, 27(2), 200-218.	Review	Medical College of Pennsylvania	No

Year	Study and Reference	Type of study	Partners	Involves direct contact with patients at CSU and/or WPH
1993	Shepherd, R. A., Bates, P. R., & McGrath, J. J. (1993). Cell cycle characteristics and schizophrenia [letter]. Biological Psychiatry, 33(1), 60-61.	Clinical observational study	Griffith University	Yes
1993	Stedman, T., & Welham, J. (1993). The distribution of adipose tissue in female inpatients receiving psychotropic drugs. British Journal of Psychiatry, 162, 249-250.	Clinical observational study		Yes
1993	Stedman, T., & Welham, J. (1993). Quality of Life Research: Helping differing people make different decisions. Australian Occupational Therapy Journal, 40, 83-84.	Review		No
1993	Whiteford, H. (1993). Australia's National Mental Health Policy. Hospital and Community Psychiatry, 44(10), 963-966.	Review		No
1993	Whiteford, H., Jarvis, M., Stedman, T., Welham, J., Csernanzky, J., & Pond, S. (1993). Mianserin-induced up-regulation of serotonin receptors on normal human platelets in vivo. Life Science, 53, 371-376.	Observational study (health volunteers)	University of Queensland, Princess Alexandra Hospital. Washington University School of Medicine	No
1993	Whiteford, H., MacLeod, B., & Leitch, E. (1993). The National Mental Health Policy: Implications for Public Psychiatric Services in Australia. Australian and New Zealand Journal of Psychiatry, 27, 186-191.	Review		No
1994	Chatterton, R., & McAllister, M. (1994). Qualitative Research in Progress: Understanding Clients' Subjective Experience During Clozapine Treatment. Schizophrenia Research(103).	Review		No
1994	Eyles, D., Stedman, T., & Pond, S. (1994). Nonlinear relationship between circulating concentrations of reduced haloperidol and haloperidol: evaluation of possible mechanisms. Psychopharmacology, 161-166.	Clinical observational study	University of Queensland, Princess Alexandra Hospital	Yes
1994	Eyles, D. W., McLennan, H. R., Jones, A., McGrath, J. J., Stedman, T. J., & Pond, S. M. (1994). Quantitative analysis of two pyridinium metabolites of haloperidol in patients with schizophrenia. Clinical Pharmacology Therapeutics, 56(5), 512-520.	Clinical observational study	University of Queensland, Princess Alexandra Hospital	Yes

Year	Study and Reference	Type of study	Partners	Involves direct contact with patients at CSU and/or WPH
1994	Gladis, M. M., Levinson, D. F., & Mowry, B. J. (1994). Delusions in schizophrenia spectrum disorders: diagnostic issues. Schizophrenia Bulletin, 20(4), 747-754.	Review	Medical College of Pennsylvania	No
1994	Keks, N., McGrath, J., Lambert, T., Catts, S., Vaddadi, K., Burrows, G., . . . et al. (1994). The Australian multicentre double-blind comparative study of remoxipride and thioridazine in schizophrenia. Acta Psychiatrica Scandinavica, 90(5), 358-365.	Clinical trial	Astra	Yes
1994	McGrath, J., & Stedman, T. (1994). How to treat schizophrenia. Australian Doctor, 10, 1-6.	Review		No
1994	McGrath, J., & Stedman, T. (1994). A mental illness which has far-reaching consequences. Australian Doctor, 28(10), 1-8.	Review		No
1994	McGrath, J. J., Pemberton, M. R., Welham, J. L., & Murray, R. M. (1994). Schizophrenia and the influenza epidemics of 1954, 1957 and 1959: a southern hemisphere study. Schizophrenia Research, 14(1), 1-8.	Mental health register study	Institute of Psychiatry	No
1994	Mowry, B. J., Lennon, D. P., & De Felice, C. N. (1994). Diagnosis of schizophrenia in a matched sample of Australian aborigines. Acta Psychiatrica Scandinavica, 90(5), 337-341.	Chart review	Multicultural Psychiatry Centre, Perth	No
1994	Whiteford, H. (1994). The first National Mental Health Report. Medical Journal of Australia, 161, 438-440.	Review		No
1994	Whiteford, H. (1994). Intersectoral policy reform is critical to the National Mental Health Strategy. Australian Journal of Public Health, 18, 342-344.	Review		No
1995	Avent, K., Van der Schyf, J., Eyles, D., & Pond, S. (1995). Measurement of a haloperidol derivative and its neurotoxic metabolites in urine. Proc.Aust.Soc.Clin.Exp.Pharmacol.Toxicol, 2, 61.	Clinical observational study	University of Queensland, Princess Alexandra Hospital	Yes
1995	Chatterton, R. (1995). Clozaril. An Australian experience. J Psychosoc Nurs Ment Health Serv, 33(4), 24-27.	Review		No
1995	Chatterton, R. (1995). Parasuicide in people with schizophrenia. Aust N Z J Ment Health Nurs, 4(2), 83-86.	Clinical observational study		Yes

Year	Study and Reference	Type of study	Partners	Involves direct contact with patients at CSU and/or WPH
1995	Hay, D., Hornsby, H., Jones, I., Mowry, B., & Mitchell, R. (1995). The potential of isonymy in psychiatric genetics. Behaviour Genetics, 25(3), 269-270.	Clinical observational study		No
1995	Lambert, T., Keks, N., J, M., Catts, S., Hustig, H., Vaddaddi, K., . . . Copolov, D. (1995). Remoxipride versus thioridazine in the treatment of first episodes of schizophrenia in drug-naive patients: a case study for specific low potency D2 antogonists. Human Psychopharmacology, 10, 445-460.	Clinical trial	Astra	No
1995	McGrath, J., & Castle, D. (1995). Influenza and Schizophrenia: A five year review. Australian and New Zealand Journal of Psychiatry, 29, 23-31.	Review	University of West Australia	No
1995	McGrath, J., Welham, J., & Pemberton, M. (1995). Month of birth, hemisphere of birth and schizophrenia [see comments]. British Journal of Psychiatry, 167(6), 783-785.	Mental health register study		No
1995	McGrath, J. J., Van Os, J., Hoyos, C., Jones, P. B., Harvey, I., & Murray, R. M. (1995). Minor physical anomalies in psychoses: associations with clinical and putative aetiological variables. Schizophrenia Research, 18(1), 9-20.	Clinical observational study	Institute of Psychiatry	No
1995	Mowry, B. J., Nancarrow, D. J., Lennon, D. P., Sandkuijl, L. A., Crowe, R. R., Silverman, J. M., . . . et al. (1995). Schizophrenia susceptibility and chromosome 6p24-22 [see comments]. Nature Genetics, 11(3), 233-234.	Clinical observational study	Erasmus University, University of Iowa, Mt Sinai School of Medicine, QIMR, Medical College of Pennsylvania,	Yes
1995	Whiteford, H. (1995). Progress in Australia's mental health reforms. Medical Journal of Australia, 163, 486-488.	Review		No
1995	Whiteford, H. A., Stedman, T. J., McGrath, J. J., Welham, J. L., & Pond, S. (1995). An open label study of famotidine as a treatment for schizophrenia. Journal of Psychiatry Neuroscience, 20(3), 239-240.	Clinical trial	University of Queensland, Princess Alexandra Hospital	Yes
1996	Ahmed, F., McGrath, J. J., & Welham, J. L. (1996). The 'Seasonality' of month of first admission for schizophrenia. Schizophrenia Research, 18(2-3).	Mental health register study		No

Year	Study and Reference	Type of study	Partners	Involves direct contact with patients at CSU and/or WPH
1996	Bates, P. R., Hawkins, A., Mahadik, S. P., & McGrath, J. J. (1996). Heat stress lipids and schizophrenia. Prostaglandins Leukot Essent Fatty Acids, 55(1-2), 101-107.	Clinical observational study	Griffith University	Yes
1996	Chatterton, R., Cardy, S., & Schramm, T. M. (1996). Neuroleptic malignant syndrome and clozapine monotherapy. Australian and New Zealand Journal of Psychiatry, 30(5), 692-693.	Clinical observational study		Yes
1996	Dark, F., Ron, M., & McGrath, J. (1996). Pathological laughter and crying: A review. Australian and New Zealand Journal of Psychiatry, 30, 472-479.	Review	Institute of Neurology	No
1996	Eyles, D., McGrath, J., & Pond, S. (1996). Formation of pyridinium species of haloperidol in human liver and brain. Psychopharmacology, 125, 214-219.	Clinical observational study	University of Queensland, Princess Alexandra Hospital	No
1996	Fananas, L., Van Os, J., Hoyos, C., McGrath, J., Mellor, C. S., & Murray, R. (1996). Dermatoglyphic a-b ridge count as a possible marker for developmental disturbance in schizophrenia: replication in two samples. Schizophrenia Research, 20(3), 307-314.	Clinical observational study	Institute of Psychiatry	No
1996	Gill, M., Vallada, H., Collier, D., Sham, P., Holmans, P., Murray, R., . . . et al. (1996). A combined analysis of D22S278 marker alleles in affected sib-pairs: support for a susceptibility locus for schizophrenia at chromosome 22q12. Schizophrenia Collaborative Linkage Group (Chromosome 22). American Journal of Medical Genetics, 67(1), 40-45.	Clinical observational study	Schizophrenia Genetics Consortium	Yes
1996	Levinson, D., & Schizophrenia Collaborative Group for Chromosomes 3 6 and 8. (1996). Additional support for schizophrenia linkage on chromosomes 6 and 8: a multicenter study. Schizophrenia Linkage Collaborative Group for Chromosomes 3, 6 and 8. American Journal of Medical Genetics, 67(6), 580-594.	Clinical observational study	Schizophrenia Genetics Consortium	Yes
1996	Levinson, D. F., Mowry, B. J., Sharpe, L., & Endicott, J. (1996). Penetrance of schizophrenia-related disorders in multiplex families after correction for ascertainment. Genet Epidemiol, 13(1), 11-21.	Clinical observational study	Schizophrenia Genetics Consortium	Yes

Year	Study and Reference	Type of study	Partners	Involves direct contact with patients at CSU and/or WPH
1996	McAllister, M., & Chatterton, R. (1996). Clozapine: exploring clients' experiences of treatment. Aust N Z J Ment Health Nurs, 5(3), 136-142.	Clinical observational study		Yes
1996	McGrath, J. (1996). The Effects of Family intervention for those with schizophrenia (invited commentary). Evidence-Based Medicine, 1, 121.	Review		No
1996	McLennan, H. R., Degli Esopsti, M., McGrath, J. J., & Pond, S. M. (1996). Mitochondrial Toxicity of haloperidol and its metabolites. Journal of the European College of Neuropsychopharmacology, 6(37).			Yes
1996	Murrell, W., Bushell, G., Livesey, J., McGrath, J., MacDonald, K., Bates, P., & Mackay-Sim, A. (1996). Neurogenesis in adult human. NeuroReport, 7(6), 1189-1194.	Clinical observational study	Griffith University	No
1996	Soares, K., McGrath, J., & Adams, C. (1996). Evidence and tardive dyskinesia. Lancet, 347(9016), 1696-1697.	Review	Oxford University	No
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Appendix 4 – Participant's voices in their own words

Appendix 4 has been provided as a separate attachment.