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Opening Up and Closing Down: Notes on the End of an Asylum

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Deinstitutionalisation describes the process in which, throughout the western world, psychiatric hospitals discharged most of their patients and most often closed their doors. It coincided with an influential rethinking of the status of the mentally ill as citizens. At Wolston Park Hospital, Queensland's first and major psychiatric facility, opened in 1865, this was an extended process beginning in the 1930s that ended only in 2001. This paper considers how this happened, over what period of time, and with what kinds of impact on the institutional community. It makes use of oral histories collected among those who worked at the hospital as well as those who were its patients and clients.

Histories of the psychiatric hospital have been dominated by the need to account for the rise of the asylum, its diffusion, and its influence in shaping the experience of the mentally ill in modern societies. A more recent interest in the continuity, through the era of the asylum, of alternative forms of care and control has not been accompanied by much historical inquiry about the decline of the massive mental hospitals that dominated the mental health landscape in the first half of the twentieth century. Instead the phenomenon of deinstitutionalisation has been understandably characterised by a focus on the changing status and experience of inmates and patients as they became 'consumers' of health services.[1] **1**

In addressing the history of deinstitutionalisation through its impact on a once very large mental hospital I want to move away a little from the patient/client focus and look instead at the institution. I want to ask what kind of stories should be told when we highlight the word 'institution' in that neologism, 'deinstitutionalisation,' that has characterised the last half century of progressive talk about the future of mental health provision. For deinstitutionalisation has been a very long process, characterising most of the postwar era. Getting patients back into the community meant opening the doors, throwing away the keys, pulling down the fences, closing down wards, and eventually terminating hospitals. It also meant reshaping workplaces, increasing accountability, changing the balance of power between staff and patients, flattening hierarchies, making some staff redundant, demanding more of everybody and rewarding only some. There were more changes in the hospital workplace between 1960 and 2000 than in the century and more before that in which nineteenth-century ideas about the form and function of the asylum had solidified.[2] The story of those changes can be told through the memories of some who worked in such a place, as well as the institutional archives which remain only partly available to contemporary researchers. In what follows I consider the decades of decline of a major public institution. **2**

From Woogaroo to The Park

The formal closure of Queensland's Wolston Park Hospital in 2001 was less an ending than another transition. This was the latest in a succession of changes that mark the generations of an institution. **3**

The original Woogaroo Asylum for the Insane was opened in 1865, a purpose built, but small facility (about 120 beds) that was one of the very first public institutions maintained by the newly self-governing colony of Queensland (separated from NSW in 1859). The Woogaroo Asylum was not only constantly relocated—its early buildings proving disastrously vulnerable to the periodic flooding of the Brisbane River—it was also endlessly renamed. Renaming reflected both changing fashions in psychiatric care and a desire to escape the stigma associated with an institution for the insane. So Woogaroo quietly became Goodna Asylum for the Insane, and then in 1898 the Goodna Hospital for the Insane.

This name survived for the next forty years, long enough to ensure that 'Goodna' might become a local idiom for asylum and 'going up the line to Goodna' a threat that needed no translation. Yet in 1940—by which time the hospital was accommodating about 1800 patients—Goodna became the Brisbane Mental Hospital. This occurred at a time when statutory authority mandated the abolition of terms like insane and asylum, and initiated the creation of a network of mental hospitals within a department of 'Mental Hygiene.'[3] In 1963 a further reordering sought to remove the stigma of 'mental' from the institution which housed nearly 2000 mental patients, now to be known as 'Brisbane Special Hospital.' 4

New thinking and new legislation justified this latest name change. The Queensland *Mental Health Act 1962* emphasised the integration of psychiatric with other health services. The title of 'Special Hospital' appeared to designate the specialised service being provided at places like the Wolston Park facility, which no longer bore an exclusive responsibility for mental illness—the mentally ill were now to be also treated in general hospitals, while the senile aged were rehoused in separate 'Eventide' homes. 5

In the late 1960s the hospital was renamed yet again, now as Wolston Park Hospital. By that time the integration of psychiatric facilities, and especially their development into community-based services, diminished the focus on regional hospitals—by 1970 the hospitals of the Psychiatric Services Division were no longer Brisbane, Ipswich, Toowoomba, and Charters Towers; but Wolston Park, Challinor, Baillie Henderson and Mosman Hall. 6

Yet when Wolston Park finally closed in 2001, Queensland Health did not vacate the site. Instead, and with considerable capital investment, numerous buildings were renovated to complement new facilities, all under the new designation 'The Park Centre for Mental Health.'[4] As this brief commentary suggests, a good deal resides in a name. The changes that accompanied the process known as deinstitutionalisation required a constant renaming of the institution. 7

Opening up and closing down

The changes captured in the term deinstitutionalisation are such that they can be described through the lens of any given framework within which can we place the hospital, its physical infrastructure, and its communities. We begin with that of the hospital's population. 8

Far from being a recent development, the closing down of Goodna took more than 60 years. When a new director of Goodna Hospital, Dr Basil Stafford, was appointed in 1938 he had the opportunity to start implementing some ideas about what he very modernly called mental hygiene; ideas gathered on a half-year tour of institutions in the US, Britain, and Europe in 1937. The lengthy report he prepared, which the government kept confidential, outlined an ambitious program of modernisation. It would be misleading to see this as an early commitment to deinstitutionalisation. But as Warwick Brunton has pointed out in the course of an insightful analysis of the process in New Zealand, any close scrutiny of the history of mental hospitals discloses just how important have been the successive attempts to counter the growth of monolithic institutions.[5] As Stafford told his minister for Health: 9

> I felt that, to be most productive, I should not confine my investigations to Mental Hospitals alone, but should bear in mind the possibility of reducing the number of patients admitted to Mental Hospitals, and of rendering

> more efficient treatment, thereby increasing the discharge rate and lessening the periods of hospitalisation, which immediately suggested activities outside hospital walls.[6]

Stafford's vision embraced early treatment, avoidance of certification, psychiatric clinics at general hospitals, a greater care and sophistication in the collection of case histories, a focus on clinical skills and research-based treatments, a broadening of the professional base to include social workers and occupational therapists, and the after-care of patients who were discharged. His comments on after-care, for example, are poignant for their reminder of how long administrators and policy makers have recognised the difficulties faced by the mentally ill outside care or custody in institutions. 'Here,' said Stafford (meaning Queensland in 1938):

> when a patient is discharged he is totally lost sight of. He is thrust from the help and protection of the hospital to compete unaided with the world. He has to battle his own way with the handicap of a recent nervous breakdown, usually stigmatised as once a lunatic and regarded as potentially a lunatic. His friends regard him with suspicion, his previous employment frequently is closed to him, and his closest relatives watch every action with hardly disguised dread. Is it any wonder that many patients who have recently regained adjustment and full resocialisation find themselves unequal to face life and continue the struggle?[7]

The thoughts were forward looking, but the necessary commitment of personnel and resources was always wanting. The interruption of war, the acceleration of population after it, the many competing demands on government during the 1940s and 1950s left Goodna struggling throughout the 1950s. When Victorian psychiatrist Alan Stoller visited Goodna as part of a national survey of mental health facilities in 1955 the only facility to which he could attach the word excellent was the 'beauty parlour, with eight cubicles and three staff.' Stafford's vision of a large professional workforce remained only that, a vision. None of the six doctors in 1955 had full psychiatric qualifications; a clinical psychologist visited this hospital of more than 2,500 patients only once a week. But there was planning for decentralisation, and the development of early treatment programs. Stafford himself (now also Director of Mental Hygiene) was spending half the week at the central Psychiatric Clinic (located in Brisbane city), which employed a number of ancillary professionals, including psychologists and speech therapists.[8] There were already signs then, of the break-up of the dominant institutional approach.

Stoller visited Goodna at the peak of the hospital's growth. From the mid 1950s the population began to decline. One factor contributing to this was the expansion of the numbers of beds for senile or dependent aged persons, in general hospital annexes or the 'Eventide' Homes. Another was a consequence of the dispersed treatment facilities, including more psychiatric beds in general hospitals and the expansion of the work of health clinics. Psychotherapeutic drugs helped some people avoid long-term institutionalisation and enabled others to be at least free of the physical restraints of straitjackets and the like. Emboldened by an overseas study tour in 1959 Stafford brought back a persuasive brief to integrate psychiatric services with general health. His annual report in that year reviewed changes in mental health policy over recent decades and highlighted the increasing vacancies in mental hospital beds, with an occupancy fall of 585 since 1954.[9] **10**

A new government, (non-Labor, replacing a Labor Party administration with an almost uninterrupted rule since 1915) may have helped shift the old ways of thinking. In April 1960 a Brisbane parliamentarian, John Herbert, explained to the public in a radio broadcast the impact of Stafford's recent report, the fundamental theme of which was 'that mental sickness and psychiatry must be integrated with medicine, and wherever practicable people must be treated in community facilities or in facilities associated with general hospitals ... Recovery is more complete and effective when it takes place in the community.' The influence of emergent critiques of institutions was evident in the minister's comment that in the past the 'mentally sick had been protected and cared for in our hospitals for such long periods that they gradually develop another illness—which may be described as over-dependence on the hospital.'[10] It was only in 1959 that Russell Barton had published *Institutional Neurosis*; Erving Goffman was yet to publish *Asylums*. In Victoria, reforming director of the Mental Hygiene Authority Eric Cunningham Dax was to publish in 1961 his book *Asylum to* **11**

Commmunity which captured the movement already well under way.[11]

12 The impetus to close down the mental hospitals was coming from within the policy and political sectors. It was driven especially by psychiatric administrators like Stafford. His overseas study tour was given some fanfare by the government, which expected a review of contemporary developments, including the 'open-door type of hospital,' day hospitals, hostels, or centres from where patients could go to work and other programmes 'designed to assist the long-term mentally sick patient to take an independent place in society.' The government was determined to 'institute the latest methods of prevention, treatment and care of all types of mental sickness.'[12]

13 Interestingly this commitment to the 'open hospital' and the integration of psychiatric with other health services stood in contradiction to some other drivers in the system. The Stoller Report[13] had done much to highlight the faults of every state's mental hospitals, including their great overcrowding. But the national government's response (under Prime Minister Robert Menzies) had been to commit money to subsidise the building of new mental hospital beds. In 1960 the Queensland government had to explain to the Commonwealth why it had not spent its allocation. The reason was that the government (under Stafford's persuasion) had stopped building mental hospitals; Queensland now preferred to see the available money spent on psychiatric beds in general hospitals. The new policy sought to return as many as possible to community life, after shorter periods of hospitalisation. Yet there were many factors still driving admissions, and so sustaining hospital populations, sometimes needlessly.

14 When Dr Orm Orford arrived in 1965 as a new medical superintendent at what was then Brisbane Special Hospital in 1965 he did so with a background unlike any superintendent before him—he was trained in psychiatry. Orford was only thirty-five years old when appointed (a controversial decision at a time when seniority still mattered). He brought with him the new perspectives on institutional dependence that Russell Barton had articulated in his study of institutional neurosis.[14] In fact, following his psychiatric training, Orford had worked with Barton at Severalls Hospital in England, not long before his appointment at Brisbane.[15] His advocacy of a new kind of hospital was pursued within and without the institution.

15 Where Stafford had started to break up the hospital population by sending geriatric patients into nursing homes, Orford paid more attention to the requirements of younger groups of chronically dependent patients. His perspectives were evident in a 1968 report on the 'rehabilitation and prevention of desocialization in those with protracted psychiatric illness.' Institutional dependence, argued Orford, was encouraged by the use of patient labour, long a core feature of the hospital but always in a service mode, assisting in the laundries or gardens. Orford wanted such a system replaced by 'Industrial therapy,' a central aspect of an ambitious 'resocialization' programme that would wean patients from their institutional dependence and facilitate their eventual discharge. The changes started slowly, with a number of areas set up as 'activity groups' supported in each case by an occupational therapist, social worker and psychologist. Very quickly the numbers of long-term patients being discharged started to increase. The report noted however the barriers to long-term success, since the 'Queensland community' had not yet provided appropriate support outside the hospital. 'A large number of our patients in mental hospitals will not be able to live under open industrial conditions in the community nor live in normal domestic surroundings.' It would take many more years to develop policies and commit resources that would match these early aspirations.[16]

16 The new regime also paid closer attention to the conditions under which some patients were being admitted. One group that seemed particularly at risk of incarceration from the late 1950s were young girls described in some reports of the time as juvenile delinquents, but considered by the hospital as 'mentally sick.' In March 1960 a Brisbane newspaper reported on a disturbance that had occurred in the hospital, under the headline 'Girls Stage Riot.' The story provoked an unusual public appeal from the health minister in defence of the treatment approach being used with a group of girls who had been accommodated together to facilitate 'group therapy and group activities.' The hospital rejected the term 'delinquent,' which conveyed 'criminality,' and appealed to the press to restrain its reporting of outbreaks of trouble which it represented as no more than 'untoward domestic incidents.' Publicity for such behaviour was likely to harm the rehabilitative aims through 'pandering to an exhibitionistic

trait that is common in the personalities of these people.' The government's concern was aggravated by continuing negative press publicity, some of which had been provoked by the Hospital Employees' Union. A few months earlier the health minister had objected to the Union's criticism of the 'behaviour of delinquent girls' at the hospital, while acknowledging the need for creation of a special facility for treatment of adolescents.[17] By the time Orford came to Wolston Park such a facility had still not been established. He early discovered what he regarded as a disturbing pattern of certification of teenage girls who in truth had little evidence of mental illness. One of his first measures in addressing the problem of institutionalisation was in fact a decision to review the status of young female residents, a step that resulted in the discharge of many of them.[18] Orford also supported the introduction of new techniques of behaviour management. But bringing about change in a system inevitably provoked conflict of another kind. One former nurse who worked on the ward accommodating these young girls recalls that her efforts to introduce behaviour limits (e.g. refusal to allow offenders to attend the pictures) resulted in other staff accusing her of cruelty. When her rationale (to avoid the use of the straitjacket) was explained to Orford he told her to keep on with her programme.[19]

17 These kinds of actions were increments along the deinstitutionalisation path. Opening up the hospital meant physical changes, including the removal of fences around wards, and bars on windows. It also demanded significant social changes, above all a reordering of gender—Orford aimed to reconstitute the hospital along clinical priorities rather than along the lines of gender segregation that had dominated for nearly a century. One symptom was the renaming of wards, replacing the old institutional nomenclature of Male 17, Female 10 etc. by 'houses' named after luminaries (mostly medical superintendents or nursing matrons) associated with the hospital's history. Such reconstitution of the fundamental divisions of the hospital was not free from its own aggravation; the integration of male and female nursing staff proved particularly troublesome, for example. Staff relations had to be carefully managed, a task Orford remembers as less taxing than might have appeared at the time, given the reputation of the unions for militancy. In fact militancy would eventually become a dimension of the other side of deinstitutionalisation, as the hospital population continued to decline and staff jobs were threatened.

18 Population decline was not an isolated factor driving the conflicts that had to be managed. For deinstitutionalisation was accompanied by reorientations that brought the status of the patient into focus. One symptom of the change was the diversification of treatment regimes, with the introduction of other health professionals, especially psychologists, occupational therapists, and social workers. In the recall of one staffer who commenced as a psychologist in 1972, much of the work undertaken at that time 'was behavioural work because a lot of the patients were not mentally ill but had behavioural problems.' Working in the admission ward she discovered 'an enormous cross section ... people with drug problems, personality disorders, depression and quite a few people with what we now call mental illness.' But the introduction of professionals with new skills provoked conflict with the entrenched authority of nurses. Aggravating the tension was the development of a more merit-based approach to the appointment of senior nursing staff. In a highly unionised workforce these tensions culminated in a long strike in 1973, a strike that this psychologist recalls as 'the end of the old era.'[20]

19 Yet there was no sudden end of the old era. As clinical practice made the individual patient the focus of attention, and multi-disciplinary teams began to characterise the organisation of the hospital, there were accompanying demands for more radical change in the status of the patient. American and British influences were significant in driving the developing critique of asylums and psychiatry in the early 1970s. The Stanford psychological experiments questioning clinical practice and assessment were mimicked in Sydney by psychologist Robin Winkler in 1973.[21] The film *One Flew over the Cuckoo's Nest* (1975), based on Ken Kesey's 1962 novel of the same name had an enormous impact in popular culture, confirming the widespread view of the mental hospital as a place of unaccountable practices and violence. In Queensland it had a very immediate echo in the title of a cheaply produced but damaging pamphlet, *Inside the Cuckoo's Nest*, authored by an academic psychologist, Jim Gardner, and documenting conditions at Wolston Park.[22] Critical newspaper commentary, common in these years, focussed attention on allegations of abuse of patients.

American example had stimulated critique and it also stimulated one remedy. In 1977 a sympathetic health minister from a government otherwise deplorable for its conservative and even repressive social policies, initiated the establishment of a new office, that of 'Patient's Friend.' It was the first such advocacy office in Australia, an idiosyncratic product of a system that was already in the throes of change. The initiative came through alliances between a representative of the new era, a young psychologist engaged in new programs aimed at recovery and restoration of patients to the community, and a hospital chaplain, with links into the Anglican church hierarchy and thence to a reforming health minister. The advocate was a person accountable to the minister, circumventing the bureaucratic and institutional channels of the hospital and Health Department. Its first and only occupant (still in the position some thirty years later) recalls the difficulty of establishing such an office, with all that it signified of a changing culture: **20**

> [The minister] came to address the staff in the Recreation Hall about the new position and what its function would be. There was a lot of paranoia and unsettledness about ... this idea of taking complaints from patients about staff. The whole idea of informing patients about their rights—now they are going to turn around and complain about us. It was a difficult period; there was even some industrial stuff.[23]

So by the 1980s the hospital had been transformed into a system in which patients had rights, whatever the institutional limits on their recognition. The ground was also being prepared for a final transformation away from the hospital as the core institution of mental health services. The establishment in the 1980s of a 'Clinical Studies Unit' was another signal of the changes. The Unit was the first substantive commitment to research at Wolston Park—although its establishment had to be massaged through an unsympathetic system which considered research a responsibility of the federal and not state government, and a workplace culture jealous of its residual rights to control matters such as work rosters.[24] An important story remains to be told of the twentieth-century history of mental hospital workforces and industrial relations. Wolston Park's history of industrial disputation during the 1970s and 1980s was yet another symptom of deinstitutionalisation's complex progress.[25]

Remembering Goodna: Still an institution

The staff who worked at Wolston Park during the decades of its demise remember it with mixed feelings. Not surprisingly that is even more the case for the patients of the hospital. But what their memories tell us is refracted through the prisms not only of institutional history, but of their own careers, whether as staff or patient. In interviews conducted for the history of the hospital, our informants started their time in the hospital at any time between the 1940s and the 1980s. Their career trajectories in some cases are flat, in others progressing up the institutional ladder, in some coming to an unexpectedly abrupt conclusion. How they capture what it meant to be in a deinstitutionalising institution is shaped then by their point of entry as much as by what they observe around them. Our representations, our images, of the strangeness of an institution to any who walk through its doors for the first time may not change that much from decade to decade, whatever the objective conditions around—such at least seems to be a lesson emerging from the memories of those working in a large mental hospital like Wolston Park. An alternative interpretation might be that the objective conditions had not changed much anyway. And a more complete account might acknowledge that both these perspectives are needed when we come to deal with the history of mental hospitals during the era of deinstitutionalisation. **21**

When the national 'Burdekin Inquiry' into the Human Rights of People with Mental Illness reported in 1993, its account of conditions in most Australian facilities suggested that many of the old problems remained. This was in spite of the major shift in policy that had resulted in a decrease in 'institutional beds' from '281 per 100,000 in the 1960s to 40 per 100,000 in 1992.'[26] Burdekin noted with alarm the possibility that some states might be on the verge of closing down all institutions without providing adequate substitute care for the most vulnerable. Whatever the case in other states, this seemed less the case for Queensland where more than half the mental health budget was being **22**

spent on three psychiatric hospitals. In spite of the ambitions as long ago as Stafford's policy advocacy in the 1950s of integrated services, progress in the development of the necessary community-based services had been slow. In this respect, whatever the *relative* rate of spending, the pattern in Queensland was familiar in other jurisdictions. Highlighting the barriers to the successful mainstreaming and integration of mental health with other health services, Burdekin summarised the continuing reality for those living with or working in mental health: 'lack of resources has bedevilled community-based care in much the same way that inappropriately allocated resources contributed to the ineptly executed demise of the large institutions.'[27]

23 In such a context it is scarcely surprising to find that memories of the institution during the long demise are mixed. On the one hand the hospital remained all too institutional, on the other it was under the pressure of constant change, producing disruption and conflict, often with some bitterness. Change was comprehensive, unpredictable, and stressful to those who had accommodated themselves to prescribed roles. At the Wolston Park reunion, attended by hundreds of former staff in 2004, some years after the closure of the hospital, one of them read his poem, 'The Big Circle Begins,' a not-too-subtle satiric take on the political and bureaucratic language that informed the institution's last years.

> Down sizing is the politically correct way to go
> We'll build a brand new complex to put on show
> Its up-to-date features will surely make other States sigh
> Is it a monument to a politician's dream or a pie in the sky?
>
> First of all we'll form the confused into a Transitions Team
> With plenty of paperwork but no answers that gleam
> Then let's determine which staff will be the ones to stay
> Offer the others a carrot and hopefully some will slink away.[28]

The world in which those who worked at the hospital—many of them members of families with a record of generations of employment going back even to the nineteenth century—had changed both inside and outside the institution. The stories told by them frequently combine nostalgic memorialisation with a restrained irony in the face of the inevitable.

24 The opening up of the hospital, and the dispersal of most of its inhabitants had other kinds of costs. The stability, security, rest, and protection sought by those who looked to a public institution could now seem out of reach. Even 'naming' changed things, and not always for the better. There was perhaps nothing more symptomatic of the altered world of Wolston Park by the 1990s than the adoption of the modern management-speak, as patients who had already become clients now became 'consumers.' The term 'consumer' lent itself to harsh comment among those who could see the limits on choice that were the consequence of severe mental illness or a profound disability. For one parent, the mother of a long-time resident with schizophrenia, the term connoted disrespect: 'I still like to call them patients, I loathe it [the word consumers], I think it's a disgusting word in relation to people.'[29]

25 Similarly Tony Caswell highlights in his poem the same kind of distaste for this new language that is also a reminder of a world that has been lost—a world in which staff cared for patients in the familiar setting of a mental hospital.

> So let's relocate our Clients and their needs we'll meet
> We're sure a lot of them will find comfort out on the street
> No concern for their safety as they flee from those who stealth
> Because their every needs will be met by Community Health.
>
> Some family and friends may be nearby to welcome them home
> Though many will be in isolated accommodation, all alone
> But we'll feel good because we have a rehabilitation program in place
> We're sure our Consumers will overcome every problem they face.[30]

For one carer, quoted above, a person who became active in advocacy support, that new language also sat strangely with the still widespread stigma associated with an institution that could never really

shed its past. Describing her fears when taking her daughter for treatment at the hospital in the late 1980s, she recalls feeling that

> it was a good thing to do even though I wasn't happy about being in a place like that. You wouldn't tell people. I told my friends in the Schizophrenia Fellowship, my family, but I wouldn't, you know because people have a perception of Wolston Park still, oh still is, you know, it's a bad place. They're trying to address that now, but it was then, it was the state facility, the lunatic asylum, you know it was the old lunatic asylum and in a lot of people's minds it still is. That's where you put really mad people ... You wouldn't go out of your way to let them know. It's the stigma that's attached to mental illness and the hospital.[31]

In this family's experience Wolston Park was also the place to go when private psychiatry failed. When her daughter became belligerent and violent the private hospitals didn't have the resources to cope: 'well she wasn't really into private psychiatrists she had to go to Wolston Park Hospital the next episode, because they wouldn't, you know wouldn't take her anymore.'[32]

The end of the hospital regime came too quickly for many, their testimony consistent with the widespread commentary that questioned political commitment to deinstitutionalisation. Asked what happened to her chronically ill daughter after 1992 this mother rapidly moves from a recall of a succession of placements in different wards to a more comprehensive criticism of lack of forward planning. **26**

> They were emptying the hospital out that was the directive they had to empty this out, never mind about what they've got out in the community, never mind about the support, never mind of what people think, none of that, they didn't have any infrastructure let's say to help those people and a lot of those people have been on the streets now and going backward and forward to the hospital, and having episodes and going backwards and forwards.[33]

The fate of those who left the hospital during these years is beyond the scope of this paper. For some, requiring continuing care or control for their own or others safety, there was to be no deinstitutionalisation. Even after the closure of Wolston Park there remains the security patients' facility in the new institution, with its five metre high steel fence and opened in 2002 with much fanfare by the premier and health minister. On site there are today a small number of stand-alone residential facilities, on the model of townhouses. In the case of one patient/inmate/client/consumer who has lived through all the changes of the last three decades, the reality remains institutional life, though under conditions which he recognises as profoundly altered since his first admission. John (we will call him) was admitted in 1979 to Pearce House, a locked ward with a very bad reputation. The routine, even many years after the beginning of the changes we have described earlier, was rigid, with showers at 6 a.m., hospital clothing, days spent in the yard behind wire, and a shower at the end of the day before tea, and then more yard time before bed. There were no personal belongings and beds were bolted to the floor. There were no toilets, a rubber bucket being used instead. Transferred to less restrictive wards, John was a beneficiary a couple of years later of the support offered in a Community Preparation Unit, before being discharged. Five years later he was back, after being picked up by police for throwing a brick through his sister's window. When he hit his psychiatrist he was transferred to the Security Patients' Hospital, then under control of the Prisons Department. Later he was transferred to the John Oxley Hospital, another security unit within Wolston Park's domain. At the time of his interview he was thus one of the institution's longest resident inmates. His characterisation of the changed environment nevertheless recognises important changes since his early days—especially the respect accorded to the individual, evident in communication about a person's needs and desires.[34]

The reality of lives such as John's suggests the resilience of institutions in the face of deinstitutionalisation. The history we have briefly considered here, a transition over some 70 years since Stafford first broached the possibility of formalising and extending the care continuing beyond the walls of the hospital, is one characterised by a slow surrender of entrenched cultural attitudes, flourishing in an institution of great longevity. Change came from within as much as without. The public and professional interest in deinstitutionalisation has been a story about what happened to **27**

patients when they became citizens with rights and interests, consumers with expectations and demands, and clients with a need for service. The mixed results are not a surprise to historians who have observed the two-hundred-year history of modern response to mental illness, with its repeated themes of neglect, hostility, and indifference, but also those of utopian enthusiasm and high aspirations. The challenge remains to translate the aspirations into a reality that meets individual needs.

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Notes

1. While there is a large historiography of the rise and influence of the asylum there has been much less attention given to its decline. For the significance of the noninstitutional histories of care and control of the mentally ill, see especially Peter Bartlett and David Wright, *Outside the Walls of the Asylum: On "Care and Community" in Modern Britain and Ireland* (New Brunswick, N.J.: Athlone Press, 1999); for a reflective and historically informed account of deinstitutionalisation in a national context, see Warwick Brunton, "The Origins of Deinstitutionalisation in New Zealand," *Health and History* 5, no. 2 (2003): 75–103; and for the larger policy and political contexts of the decline of the asylum, see for example Andrew Scull, "The Asylum as Community or the Community as Asylum: Paradoxes and Contradictions of Mental Health Care," in his *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (Berkeley: University of California Press, 1989); Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994); Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London: Athlone Press, 1993).

2. For the most recent consideration of the asylum as a workplace, a relatively neglected theme in the historiography, see Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum* (Amsterdam: Rodopi, 2008).

3. Queensland, *Mental Hygiene Act 1938*.

4. For a review of the 'institutional reform process' that formed a background to the eventual closure, see Jennene Greenhill and Donald Stewart, eds, *Outcomes in Public Policy. Institutional Reform and Mental Health: A Case Study in Building Better Cities* (Brisbane, 1995).

5. Brunton, "The Origins of Deinstitutionalisation in New Zealand." See also Stephen Garton, " Changing Minds," in *Australians from 1939*, edited by Ann Curthoys et al. (Sydney: Fairfax, Syme & Weldon Associates, 1987).

6. Basil Stafford to Minister for Health and Home Affairs, [1938],enclosing Report on Modern Trends in Administration & Treatment of Mental Diseases, Queensland State Archives (hereafter QSA), A/31781 (45/8786).

7. *Ibid.*, 29.

8. Alan Stoller, *Report on Mental Health Facilities and Needs of Australia* (Canberra: Government Printing Office, 1995), 98, 102.

9. Queensland Dept of Health and Home Affairs, *Annual Report of the Health and Medical Services 1959—60*, (Queensland Parliamentary Papers), 77.

10. John Herbert MLA, Address for broadcast, 17 Apr 1960, QSA, A/72509.

11. Russell Barton, *Institutional Neurosis* (Bristol: Wright, 1959); Eric Cunningham Dax, *Asylum to Community: The Development of the Mental Hygiene Service in Victoria, Australia* (Melbourne: Cheshire, 1961); Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Doubleday & Co, 1961). On Dax, see Belinda Robson, "An English Psychiatrist in Australia: Memories of Eric Cunningham Dax and the Victorian Mental Hygiene Authority, 1951–1969" *History of Psychiatry* 13 (2002): 69–87.

12. Ministerial press release, 27 Jan 1959, QSA A/72509.

13. The Report was delivered in response to the Commonwealth Government's interest in reviewing a Commonwealth-State agreement of 1948 on the funding of psychiatric facilities: for the context, see Milton Lewis, *Managing Madness: Psychiatry and Society in Australia 1788–1980* (Canberra: Australian Government Publishing Service, 1988): 77–9.

14. Barton, *Institutional Neurosis*.

15. For the significance of Severalls in the English psychiatric scene in the early 1960s, see Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913–1997* (London: Routledge, 1998).

16. Queensland Dept of Health and Home Affairs, *Annual Report of the Health and Medical Services 1967—8* (Queensland Parliamentary Papers), 44–5.

17. Ministerial statements, 7 Mar 1960, 29 Jan 1960, QSA, A/72509.

18. Orm Orford, interview with Deborah Gilroy, 20 October 2002.

19. Anonymous, interview with Deborah Gilroy, 3 February 2003.

20. Anonymous, interview with Deborah Gilroy, 11 July 2002.

21. Paul Laffey, "Antipsychiatry in Australia: Sources for a Social and Intellectual History," *Health and History* 5, no. 2 (2003): 17–36.

22. Jim Gardner, *Inside the Cuckoo's Nest: Madness in Australia* (Brisbane: Planet Publishing, 1977).

23. Nadia Beer, interview with Deborah Gilroy, 11 July 2002.

24. Anonymous, interview with Deborah Gilroy, 17 July 2002.

25. Greenhill and Stewart, *Outcomes in Public Policy*, 93–103 gives a perspective on some of the strains of restructuring during the last decade of the hospital. The importance attached to industrial relations and negotiations with workplace unions in the 1983 Richmond Report (NSW) is a comparable example: See David T. Richmond, *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* (Haymarket, NSW: NSW Department of Health, Division of Planning and Research, 1983).

26. Human Rights and Equal Opportunities Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness* (Canberra: Australian Government Publishing Service, 1992), 145 and chapter 5.

27. *Ibid.*, 137.

28. Tony Caswell, *The Big Circle Begins*, excerpt. I am grateful to Tony Caswell for making available the text of his poem, which I heard read by him at a Wolston Park reunion, 7 March 2004.

29. Mother and advocate, interview with Deborah Gilroy, 20 March 2003.

30. Caswell, excerpt.

31. Mother and advocate, interview with Deborah Gilroy.

[32.] *Ibid*.

[33.] *Ibid*.

[34.] Patient, interview with Deborah Gilroy, 30 Jan 2003.
