

*Introduction:
Deinstitutionalisation in Australia
and New Zealand*

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Colin Jensen, 57, can no longer go to the MCG to see his beloved Magpies [Collingwood Australian Rules Football Club]... Niki Sheldon, one of the advocates at DJA [Disability Justice Advocacy]... [and] one of the advocates for Colin Jensen, who receives the maximum 34 hours a week care under a package called Home First... says... 'Because his physical disability is so high it is already so expensive for him to live, so he uses all of this funding to survive in the home. There is no way to get him out because the 34 hours cannot be stretched.' She [adds]... 'He has become locked up in his home. I don't know how he has the patience to sit at home all day doing nothing.' When Colin... was younger, he was a disability advocate... Now he sees the system, which is largely privatised, failing the people it was set up to help. In addition to a Collingwood premiership, Jensen says he would dearly like an extra 12 hours of attending care a week. 'I would like to go shopping, visiting friends and go to the meetings like I used to in the old days.' [Alison Dean, *Melbourne Times*, 9 April 2003] ¹

THE WIDESPREAD DEINSTITUTIONALISATION OF THE MENTALLY ILL AND those people with an intellectual and physical disability in the Western world has proved to be one of the most radical and controversial mental health policy initiatives of the twentieth century. As a topic of study for historians of psychiatry within the field of the history of medicine it remains, as yet, predominantly unexplored. This is particularly the case in Australia and New Zealand. What literature exists about deinstitutionalisation is multidisciplinary. The ramifications of deinstitutionalisation for those people like Colin Jensen (above) living with the effects of 'community care' are a focus of media attention that questions the state and nature of such care for these people, their families, and friends, for whom this is a reality. We have chosen to focus on the topic of deinstitutionalisation for this Special Issue of *Health and History*, with the aim of initiating and invigorating academic discussion about a highly contested 'policy' that has been in operation since the 1950s.

Following the Western world's era of deinstitutionalisation, a time when psychiatric institutions were closed and replaced by various models of 'community care' and 'community psychiatry', history writing about psychiatry has taken different forms. A growing sense of relevant themes—including the importance of memories of institutions, the meanings of psychiatric knowledge, different forms of treatments and new psychiatric communities, as well as policy shifts—has contributed to an exciting new period of historical writing. This issue contains six articles that explore deinstitutionalisation in Australia and New Zealand in different ways focusing on the following themes: the rise of the antipsychiatry movement in Sydney, Australia; the implications of the shift from custodial care to community care for residents of Kew Cottages in Melbourne, Australia; alternative treatment methods for mental illness in Ward 10B, Townsville, Queensland, Australia; policy and practice in combating the effects of institutionalisation and the implications this has for deinstitutionalisation in New Zealand; the importance of institutional histories using the case study of Tokanui Hospital, New Zealand; and the use and nature of images of music and madness in Australian and New Zealand newspapers and official histories.

In this issue we have attempted to provide a balance of articles that both explore aspects of Australia and New Zealand and also signal the potential comparisons between the experiences of deinstitutionalisation in these places. There are, however, important areas that are not addressed here and that need further explication, including those on the following topics: deinstitutionalisation and Indigenous mental health and disability; deinstitutionalisation and its impact on mental health and disability care in regional Australia and New Zealand; deinstitutionalisation and service provision in the growing area of aged care; and deinstitutionalisation and the provision of fundamental mental health and disability services to those in need in non-health care institutions such as prisons, and asylum-seeker detention centres. We hope that readers of this Special Issue will take up some of these topics and that, in time, *Health and History* will solicit articles that deal with these ideas.

As Catherine McDonald has observed in another context, 'institutional change can involve both deinstitutionalisation and reinstitutionalisation'.² Deinstitutionalisation has seen the plight of some of those people with mental illness and physical and intellectual disability removed from one form of incarceration only to end up in another. In steadily increasing numbers, sufferers of mental illness commit crimes and find themselves in the prison system, which does not have the institutional mental health facilities to deal with their needs. The mental health of asylum seekers in immigration detention centres is a further

example of a serious breakdown in the provision of appropriate mental health services within another institutional framework. Advocacy groups have raised these political issues, most recently on 12 May 2003 when the Mental Health Council of Australia (MHCA) issued ‘a call to Immigration Minister Philip Ruddock... to address the mental health care of asylum seekers in Australia’s detention centres’.³ It is, therefore, important to start to understand the historical dimensions of deinstitutionalisation as an ideology, a policy and a varied practice within an Australian and New Zealand mental health context.

The history of deinstitutionalisation and ‘community care’

In April 2003 the MHCA released its *‘Out of Hospital. Out of Mind!’ Report*, in which it demonstrated the disparity between mental health care policy initiatives and policy implementation across Australia. It is a disparity that has resulted in limited access to and availability of services, poor continuity of care, continuing community stigmatisation of mental illness, and a lack of sufficient funding and appropriate resources for community-based care services for those with mental illness.⁴ The implications for the failure of community care were first outlined in Brian Burdekin’s now widely disseminated findings in his 1993 *Human Rights and Mental Illness Report*.⁵ The Burdekin Report outlines what it termed ‘the extensive implications of such an inadequate “system” of community care’, and analysed in detail the complex plight of the mentally ill within the community.⁶ Yet deinstitutionalisation has been the main policy initiative of mental health systems in the Western world since World War II. A feature of the welfare state system has been the adoption of deinstitutionalisation rhetoric in policy and practice during a period of economic boom in Australia, New Zealand, Britain, and the United States.

Deinstitutionalisation is a broadly used term with a less than clear definition. In some places, including the US, it is most often associated with intellectual and physical disability. Shulamit Ramon states that ‘concepts of dehospitalisation, deinstitutionalisation and demarginalisation... were initially developed in the United States and Western Europe during the 1960s’.⁷ Issues of human rights were central to these debates. There are two clear strands governing mental health care and deinstitutionalisation: the medical model, which places psychiatry and psychiatric hospitals as the means to treat mental illness; and the sociological model, in which prevention, rehabilitation and treatment occurs at psychiatric units in general hospitals and operates in conjunction with social services in the community. The latter

model has focused on issues of human rights, deviance, social control, socialisation, and rehabilitation within the community. It has resulted in a division among health practitioners between those in favour of normalisation and integration policy and practice, and those against. Roger Trowbridge observed the effect that this terminology has had on intellectual disability in the Australian context:

the historical convergence of these two traditions of normalisation and integration in Australia has had a powerful effect upon the disability field. This is reflected in legislation, policy, funding priorities and professional training, literature and program design.⁸

Integration and normalisation are terms most commonly associated with community care.

According to Beth Wilson, an advocate for public administration and ethical practice in the areas of the law and health in Victoria, ‘deinstitutionalisation is essentially a policy designed to reorganise mental health resources away from the institutions and into the community’.⁹ Often linked with terms such as ‘mainstreaming’ and ‘community care’, deinstitutionalisation has ‘the best of intentions—to provide better services and to reduce the stigma and isolation that the mentally ill have endured’.¹⁰ In the Western world, mental health care in the community was a product of post-World War II policy development. Anne Leonard stated that while ‘large-scale institutions have been under fire from their earliest days’ there was a renewed vigour in this criticism ‘especially in the period since 1945’.¹¹ Virginia Berridge has observed, also in the context of Britain, that while ‘hospital-based technocratic medicine dominated health services’ from the 1950s ‘another policy objective’ emerged that aimed to ‘remove sections of institutional populations into what became known as community care’.¹²

Policies of deinstitutionalisation sought to achieve this outcome in conjunction with two other related policies: mainstreaming, which ‘aims to provide services for mentally ill people in general hospitals and as part of the general health services’ with the aim of bringing ‘psychiatric services out of isolation... and thereby reducing the stigmatisation of the mentally ill person’; and community care, which centred on a caring community supporting sufficient ongoing funding to provide services to enable and ‘support people with mental illness within the community’.¹³ The success of deinstitutionalisation relied upon the utopian assumption that the community at large did care about people with mental illness and disability. Ideally, policies of deinstitutionalisation pushed the provision of mental health care services away from the isolated and centralised institutional model of mass care, towards a model in which the provision of appropriate services was

based on, and catering for, individual client needs. As the Richmond Fellowship in London concluded:

Most of us, when asked what we want from life, will put health near the top of our list of priorities. We would also like a secure home, good personal relationships, a satisfying occupation, absorbing interests, and adequate income.¹⁴

In Australia in 1954–55 Alan Stoller and K. W. Arscott completed their report *Mental Health Facilities and Needs of Australia*, which examined the level, nature and gaps in psychiatric institutional services.¹⁵ As Kenneth Kirkby conclude:

up until the 1960s psychiatry in Australia was practiced in a predominantly institutional setting, but there was a range of other developments. The history of community based approaches to psychiatry in Australia has been detailed by E[ric] C[unningham] Dax, who played a prominent role in the process.¹⁶

Dax's own work, *Asylum to Community*, published in 1961 was instrumental in Victoria. Central to the success of deinstitutionalisation and community care was the provision of psychiatric services within the community, and what the psychiatric profession in Australia and New Zealand from the 1970s referred to as 'community psychiatry'. In 1975 the *Medical Journal of Australia* 'reviewed the position of community psychiatry in Australia' pointing out that 'ever since the hospitals had placed patients in the community, there had been dispute as to whether the patients were gaining freedom and independence or simply being callously neglected'.¹⁷ In 1979 Lenora Lippmann acknowledged the significant influence of American literature in the Australian context and quoted the definition of 'community psychiatry' as defined by G. Caplan, that 'the philosophy of the community psychiatry movement revolves around the concept of delivery of psychiatric services according to the needs of the community—that is, when where and how required [*sic*]'.¹⁸ The US literature professed that community psychiatry was 'the third psychiatric revolution'.¹⁹

Yet Milton Lewis perceptively pointed out that in the context of the 1950s Australian psychiatry was not only 'divorced from the mainstream of medicine... but it was also not a very highly regarded area of medical specialisation'.²⁰ Lewis added that psychiatrists considered there was a major stumbling block between an integrated psychiatry within health services policy rhetoric and the reality, as 'there existed a gulf between psychiatry and medicine which meant that a move from one sphere to the other could not unreasonably be seen as the con-

temporary equivalent of interplanetary travel'.²¹ By the 1970s professional divisions and animosities had emerged in America, Britain and, to a lesser degree, Australia and New Zealand between psychiatry, psychology and sociology.²² The central issue was that psychiatry firmly believed that mental illness was treatable through a medical model, while psychology and sociology questioned and, in some instances, denied the concept of mental illness, opting instead for recognition of those symptoms as 'behavioural maladjustments' that should be treated 'outside the medical orbit' through rehabilitation and socialisation.²³ As the editorial in the *Medical Journal of Australia* observed in 1975, 'the opening-up of mental hospitals was a battle not easily won, and it would be a pity if the mental health profession and its critics lost sight of the good which community care has done for many thousands'.²⁴ The journal added, 'the fact remains that life in a mental hospital still carries with it elements of institutionalisation, control, regimentation and dependency, which can never be removed'.²⁵

The decentralisation of services was seen to benefit the community by providing broader access to mental health services in both rural and urban areas. Lewis observed for Australia that:

in the 1970s the pattern of development of community services differed somewhat from State to State, but the movement away from the centrality of institutional care was common to all. Some States attempted to integrate mental and physical health services, both at the upper level of administration and at a local level delivery, and in this development they reflected worldwide recognition of the holistic nature of health.²⁶

Increasingly by the 1970s, community care was 'identified with the closure of long stay hospitals for the mentally ill and handicapped, thereby promoting controversy about a lack of adequate replacement facilities'.²⁷ Furthermore, as Berridge concluded, there was a subtle 'shift in policy from care in the community to care by the community that also occurred in the 1970s and 80s'.²⁸

Yet definitions of community care were imprecise and covered formal health service care within the community as well as informal care provided by family and friends. In Australia 'one of the central problems for the community services was that the objectives which they were to pursue were left general and there was little articulation of specific goals'.²⁹ Although conservative governments in the Western world increasingly pushed for care by the community, the reality was a growing realisation of the shared responsibility between government provision of mental health and disability services, private service providers, voluntary groups, and informal care by families and friends within the community as expressed through government policies.

Charles Fox's work in the history of intellectual disability is well known, most notably for the ground-breaking *Under Blue Skies: The Social Construction of Intellectual Disability in Western Australia* (1996) co-edited with Errol Cocks, Mark Brogan and Michael Lee.³⁰ In his article for this issue, 'Debating Deinstitutionalisation', Fox explores the different meanings given to 'community' as Kew Cottages in Melbourne faced the deinstitutionalisation of its population of the intellectually disabled. Through his examination of a serious fire that occurred at Kew Cottages in 1996, in which nine men died, Fox shows that the concept of 'community' was contested and debated and that deinstitutionalisation was not adequately defined.

In New Zealand, as the authors of a report about the late 1980s deinstitutionalisation of a group of intellectually disabled people at Tokanui Hospital in the North Island have argued, the process of deinstitutionalisation was embarked upon 'somewhat more cautiously than in other parts of the world'.³¹ Yet there, too, concepts of community care have been fiercely debated.³² In the British context, Shulamit Ramon questioned whether the psychiatric system could embark upon deinstitutionalisation and normalisation given that its present position was simply one of what he termed 'dehospitalisation'.³³ Ramon made the critical distinction between the rapid emptying and closure of psychiatric hospitals on the one hand, and the community care policy rhetoric on the other. Ramon observed that the process of dehospitalisation had resulted in 'two psychiatric hospitals' in Britain being 'completely closed during 1987, as compared to none between 1959 and 1986'.³⁴ By 1991, according to Philip Bean and Patricia Mounser, 'the Department of Health closed 60 of Britain's psychiatric hospitals, thereby reducing the 70000 hospital beds to 43000'.³⁵ Ramon identified four critical factors in these hospital closures: 'the initiative for change came from the health management, and not from the professionals or the community'; 'patients were assessed individually' and provided with 'a short rehabilitation stage inside the hospital'; 'no attempt was made to change the hospital regime'; and, adopting a user-pays model, 'the sites were sold to commercial developers and the proceeds used to finance change'.³⁶

Ideology and policy

The decision to move towards deinstitutionalisation or dehospitalisation and community-based services in the Western world in the late 1950s was accompanied, by what Kathleen Jones has termed, the 'ideologies of destruction' that supported the call, from various political positions, for the wholesale dismantling of the mental hospital/asylum

system of incarceration. Three different yet internationally influential theoretical positions supported those sectors of the wider community calling for change: Erving Goffman's *Asylum: Essays on the Social Situations of Mental Patients and Other Inmates* (1961); Michel Foucault's *Folie et Dérison: Histoire de la Folie à l'âge Classique* (1961) [*Madness and Civilisation: A History of Insanity in the Age of Reason* translated into English in 1965]; and Thomas Szasz's *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1961).³⁷ These texts have been widely associated with the antipsychiatry movements in different countries mentioned here, including Australia and New Zealand. But in each place the antipsychiatry movement was characterised and constituted differently. Paul Laffey's paper offers useful perspectives on researching the antipsychiatry movement in Australia, indicating that the expression of key ideas in professional journals, including the *Australian and New Zealand Journal of Psychiatry* and the *Medical Journal of Australia*, was part of the broader context of the post-World War II period in Australian psychiatry. In the 1960s, psychiatry entered a period of anxiety when 'the profession... seemed to be caught at an unenviable historical junction'. In an Australian context Milton Lewis observed:

in the decade or so following World War II a variety of new treatments were developed. New concepts concerning the organization of psychiatric care, both in hospitals and in the community at large, helped shift emphasis from traditional custodial care in large, closed institutions to maintaining the patient in the community.³⁸

The plan for psychiatric services in the Australian Capital Territory (ACT) in 1969 contained a brief summary of the thinking at that time:

Mental Health Services throughout the world are now being rapidly reorganised along preventative, early treatment, and rehabilitative lines, on a decentralised and regional basis. This enables those in need of psychiatric help to receive it in their own home. This also requires the closest possible contact between Psychiatric Service personnel and other Health and Welfare workers, particularly General Practitioners. These general lines of development are strongly recommended as the basis for the ACT Psychiatric Services.³⁹

Furthermore, there was an emphasis given to the new treatment methods available—the benefits of 'the pharmaceutical age' and that 'drugs have been complemented by group and family therapy programmes and a growing emphasis on prevention'.⁴⁰ The rhetoric of 'mental health' rather than 'mental illness' was firmly established. Emily Wilson's arti-

cle in this Special Issue critically explores one aspect of the new treatments offered under the rubric of the ‘therapeutic community’ in Ward 10B at Townsville’s General Hospital in Queensland in the 1970s and 1980s. This particular example shows the importance of discussing the context of policies of deinstitutionalisation when treatments and changes occurring within psychiatric practice are evaluated.

The effects of deinstitutionalisation

The effects of deinstitutionalisation removed the geographical specificity of mental health care provision by replacing it with community-based services. As Diana Gittins observed in her history of Severalls Hospital near Colchester in Essex, England, between 1913 and 1997,

instead of services and resources being consolidated in one space within a unified group of buildings, they are now provided in a more indeterminate and fragmented spatial framework where networks of community psychiatrists, doctors, psychologists and social workers work on a one-to-one basis with patients dispersed over a wide area.⁴¹

Furthermore, as Joan Busfield has observed, the asylum had been the forum in which psychiatry has asserted its professional dominance: ‘with the decline of the asylum the professional dominance of psychiatrists has diminished somewhat, a decline heightened by the proliferation of other mental health professionals’.⁴²

The actual outcomes of deinstitutionalisation were hampered by funding constraints. Busfield concluded that

in practice the long-stay inmate population have been subject less to a process of deinstitutionalisation, than to one of transinstitutionalisation, often ending up in boarding-houses, nursing homes, homes for the elderly, or even prisons, as well as a few purpose-built facilities.⁴³

Gittins concurred, stating ‘people who in earlier times would have almost certainly been labelled mentally ill and sent to mental hospitals, are increasingly being imprisoned, confined without treatment’.⁴⁴ In the British context, by 1957

community care, as initially envisaged, aimed to develop services such as halfway houses and training centres outside the mental hospital... [and] these services were still to be publicly funded and it was the cost of alternative provisions that hampered the implementation of community care in the 1960s and 1970s.⁴⁵

By the 1980s, psychiatric populations began a steady and then increasingly rapid decline as a result of policies of deinstitutionalisation, culminating in the mid- to late-1990s. Community care covered anything that ‘did not involve residence in a large institution’, and, as Busfield added, ‘indeed, the term does not require that there be any professional service at all, and informal care by family and friends, let alone homelessness and neglect’ could ‘all fall within the framework of community care’.⁴⁶ Furthermore, patients were being afforded a

new status based on an ideal of the individual, the need for individual space and privacy, and the desirability of individual choice, symbolised by the shift from using the implicitly passive term ‘patient’ to the more active, consumer-oriented term ‘client’.⁴⁷

Deinstitutionalisation and history

Although strongly associated with the period 1940 to 1970, the concept of deinstitutionalisation was not a twentieth-century development. The historical patterns of institutionalisation and the progressive ‘opening up’ of institutions are discussed in Peter Barham’s 1992 book, *Closing the Asylums: The Mental Patient in Modern Society*.⁴⁸ In 1996 Andrew Scull’s chapter ‘Asylums: Utopias and realities’, in Dylan Tomlinson and John Carrier’s *Asylum in the Community*, suggested that the term asylum itself has ‘undergone striking changes of meaning’ over two centuries.⁴⁹ Mark Finnane has recently charted the evolution in Australian history from dangerous lunatic to human rights by examining the interaction of legal and mental health policy and legislation.⁵⁰

Also writing about Australia, David McCallum has observed that ‘much of traditional Australian medical historiography’ is consistent with C. J. Cummin’s conception of ‘the “birth of psychiatry” in the 1840s’ with the creation of the asylum and its control by ‘medical’ men.⁵¹ This historiography relies on an assumed ‘prior existence of madness, independently of its historically specific forms of calculation’. Social history, ‘in contrast to these histories... focuses on the events which helped to determine the construction of the categories themselves’.⁵² In his recent overview of Australian histories of the asylum and of ‘madness’, Stephen Garton explores the shift from ‘medical’ histories of ‘madness’ to social and cultural histories, and argues that much more work in specific areas needs to be undertaken in this broad field.⁵³

Histories of insanity, the asylum and mental health follow a similar pattern in New Zealand. In this Special Issue, Warwick Brunton explores historical policies of deinstitutionalisation in New Zealand.

In both countries new histories of ‘madness’ and the asylum have appeared in recent years showing a renewed attention to these topics and a broader sense of what this field includes. In Barbara Brookes and Jane Thomson’s *Unfortunate Folk: Essays on Mental Health Treatment 1863–1992* (2001), a number of chapters focus on the twentieth century and on the effects of policies of deinstitutionalisation.⁵⁴ Our own *‘Madness’ in Australia: Histories, Heritage and the Asylum* (2003) also includes several chapters about contemporary issues in the history of institutions and psychiatry.⁵⁵ While both these collections acknowledge the gaps in their studies, other historians, including those selected for this Special Issue, writing about psychiatry in recent decades have commented upon psychiatric practices during and following the era of institutional closures. Dolly MacKinnon’s article explores why images of music as a therapeutic remedy within psychiatric institutions appear in the popular Western press and in Australia and New Zealand from the 1850s until the 1940s, and examines what they actually represent in terms of cultural beliefs concerning madness, and music as medicine over time. It considers how the press understood and represented music as therapeutic to the community, and examines how historians of psychiatry have read these images in recent historiography. The article then considers why there has been a resurgence of the use of these images most recently by professional groups in commissioned commemorative histories about the asylum. These Australian and New Zealand images need to be understood within their Western context, and the article investigates how they reflect medical, musical, moral, and cultural understandings of music as medicine, which can be traced from classical antiquity.

Ramon has questioned the potential for the practical uses of ‘the recent critique of psychiatry in general... from sociology and [the] history of medicine’, namely the work of Peter Miller, Nikolas Rose, William Bynum, Roy Porter and Michael Shepherd, for ‘those interested in changing the psychiatric system’.⁵⁶ Ramon claimed that although

sophisticated in terms of issues raised [women, and ethnic minorities] and the level of analysis, most of it is too removed from the everyday reality of psychiatry, and especially the reality of users’ to be of use in any practical sense.⁵⁷

Yet, implicit in this criticism is a realisation of the potential value of historical and sociological studies in providing a broader knowledge of the changing social, cultural and policy understandings of deinstitutionalisation to the community at large, and the impact this has on the users, carers and professional groups involved in this process. Perhaps then we need to reconsider Michel Foucault’s ‘method of

enquiry', which he described as 'histories of the present' in which 'the use of historical investigation' is 'for the purposes of diagnosing problems in the here and now'.⁵⁸ For McCallum, Foucault has extended an 'intellectual invitation' in which historians should be 'charting new territories and formulating questions in different sorts of ways' that may assist in a greater community awareness and understanding of mental illness and intellectual disability.⁵⁹

In practice the two strands of deinstitutionalisation have focused on the mentally ill first and the intellectually and physically disabled second. McCallum has addressed the medical and legal recognition, classification and separation of the concepts of mental illness and intellectual disability in the legal separation of these two classifications which were a corner stone of English common law:

the first half of the twentieth century saw the gradual separation, both administratively and geographically, of an aggregate population into the mentally ill on the one hand, and the mentally defective and mentally deficient on the other.⁶⁰

The subsequent deinstitutionalisation and dehospitalisation occurred first with the mentally ill and then with the intellectually and physically disabled.⁶¹ Indeed, in the second phase in Victoria the process of 'community alternatives' to institutionalisation for the residents of Kew Cottages is still being thrashed out between the State government, client advocacy groups, and clients' families, property developers and the community.⁶² For Patricia Moynihan, patients' freedoms were 'tempered by three... factors': 'deinstitutionalisation' was achieved through a process of 'trans-institutionalisation'; social control was continued within the community through the "normalisation" programs; and the extension of supervision within the community'.⁶³

As Warwick Anderson cogently observed in his keynote lecture at the Australian Society for the History of Medicine Conference in Melbourne in 2003, tracing the intellectual networks of scientific ideas is an essential feature of understanding medical and scientific knowledge, developments and practice. Early psychiatric knowledge networks spanned Britain, Europe and America, and through the constant migration of medical practitioners from these countries to colonial settler colonies like Australia and New Zealand, these medical ideas flourished and influenced both mental health policy and practice. Charles Mercier's influential work *Lunatic Asylums: Their Organisation and Management*, published in London in 1894, is cited and quoted verbatim as evidence by Dr Henry Byam Ellerton in the Royal Commission in Queensland 1915. These intellectual networks are hinted at by the bookplate inside the University of Melbourne's 1894 copy of Mercier's

book: 'This volume is on indefinite loan from The Library, Parliament of Victoria to the University of Melbourne' date stamped '5 April 1979'.⁶⁴ Here psychiatric knowledge influences public policy.

The influence of these types of works on Australian and New Zealand policy, education and medical practice cannot be underestimated. Most recently, from an historical archaeological perspective, Susan Piddock has examined the influence of John Conolly's concept of the 'ideal asylum' in the construction of asylums in South Australia in the nineteenth century.⁶⁵ In his article, 'The Origins of Deinstitutionalisation in New Zealand', Warwick Brunton examines the influence of the works of John Conolly, Charles Mercier and other theorists in New Zealand's experience of institutionalisation. Thus, another aspect of this Special Issue is the consideration of the colonial context for psychiatry and its institutions in Australia and New Zealand. Catharine Coleborne also examines the New Zealand context by exploring the potential for a history of Tokanui Hospital (1912–98) and suggesting that histories of specific institutions might also deepen the study of the era of institutional closures. Writing about Australia, Garton has suggested that institutional histories are important to the development of histories of psychiatry.⁶⁶

The collecting of memories from professional nursing staff, patients or clients is a vital aspect of institutional history and has taken on new significance with the increasing importance of oral history theory and method in recent decades. The process of recalling the past of the institution inevitably involves nostalgic memories. Colin Jensen, quoted at the beginning of this introduction, commented that 'he would like to go shopping, visiting friends and go to the meetings like... [he] used to in the old days'.⁶⁷ Here Colin's nostalgia is for his youth and the greater social interactions he enjoyed. A sensitive critique and appraisal of the life of the psychiatric institution, and those who lived and worked within it, must form a core of the analysis of the future history of psychiatry.

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1. Alison Dean, 'Don't Get around Much any More', *Melbourne Times*, 9 April 2003, pp. 8–9.

2. Catherine McDonald, 'Deinstitutionalised or Reinstitutionalised? Developments in the non-profit human services sector', *Australian Journal of Social Sciences*, vol. 32, no. 4, November 1997, p. 352.

3. Mental Health Council of Australia (MHCA), Media Release, Monday 12 May 2003.

4. MHCA, 'Out of Hospital. Out of Mind!' *A Report Detailing Mental Health Services in Australia in 2002 and Community Priorities for National Mental Health Policy for 2002–2008*, MHCA, April 2003.

5. National Inquiry into the Human Rights of People with Mental Illness, *Human Rights and Mental Illness: Report of the National Inquiry into Human Rights of People with Mental Illness*, Brian Burdekin, Commissioner, Australian Government Publishing Service, Canberra,

1993, vol. 1, p. 328. The 'conclusion' regarding 'community care' states: 'There are fundamental and widespread inadequacies in the "community care" available to the majority of Australians affected by mental illness. These deficiencies are incompatible with the rights of those individuals to appropriate care, treatment and rehabilitation and in some instances compound the ignorance and stigma still commonly associated with mental illness.'

6. See *Human Rights and Mental Illness*, vol. 1, part 2, and vol. 2, part 3.

7. Shulamit Ramon, *Mental Health in Europe. Ends, Beginnings and Rediscoveries*, Macmillan Press, London, 1996, p. 44.

8. Roger Trowbridge, 'Disability and Productive Employment: A prediction of failure and a proposal for Change', *Australian Journal of Social Issues* (hereafter *AJSI*), vol. 28, no. 1, February, 1993, p. 52.

9. Beth Wilson, 'Shifts in Mental Health Policy', in Linda Hancock (ed.), *Health Policy in the Market State*, Allen & Unwin, St Leonards, NSW, 1999, p. 252. See also Bill Healy & Helen Varney, 'Mainstreaming and Integrating Psychiatric Services: The Victorian experience', *AJSI*, vol. 30, no. 2, 2 May 1995, pp. 179–94.

10. P. R. Beson, 'Deinstitutionalisation and Family Caretaking of the Seriously Mentally Ill: The policy context', *International Journal of Law and Psychiatry*, vol. 17, no. 2, 1994, pp. 119–38, cited in Wilson, 'Shifts in Mental Health Policy', p. 252.

11. Anne Leonard, *Homes of Their Own: A Community Care Initiative for Children with Learning Difficulties*, Avebury, Aldershot, 1991, p. 7.

12. Virginia Berridge, *Health and Society in Britain Since 1939*, Cambridge University Press, Cambridge, 1999, p. 34.

13. Wilson, 'Shifts in Mental Health Policy', pp. 252, 255.

14. *Mental Health and the Community*, Report of the Richmond Fellowship Enquiry, [London], 1983, p. 1.

15. Alan Stoller & K. W. Arscott, *Mental Health Facilities and Needs of Australia*, Government Printing Office, Canberra, 1955, presented to the Minister for Health, Commonwealth of Australia.

16. Kenneth C. Kirkby, 'History of Psychiatry in Australia, Pre-1960', *History of Psychiatry*, vol. 10, 1999, pp. 202, 204. See also Belinda Robson, 'An English Psychiatrist in Australia: Memories of Eric Cunningham Dax and the Victorian Mental Hygiene Authority, 1951–1969', *History of Psychiatry*, vol. 13, 2002, pp. 69–87. As Kirkby observes, Dax has also contributed to this history. See E. C. Dax, *Asylum to Community*, F. W. Cheshire, Melbourne, Victoria, 1961, and 'The Evolution of Community Psychiatry', *Australian and New Zealand Journal of Psychiatry* (hereafter *ANZJP*), vol. 26, 1992, pp. 295–301.

17. *Medical Journal of Australia* (hereafter *MJA*), vol. 1, 1975, p. 797.

18. Lenora Lippmann, 'Community Mental Health Ideology in Victoria', *Australian and New Zealand Journal of Sociology*, vol. 15, no. 3, November 1979, pp. 39–44, especially p. 39.

19. Lippmann, 'Community Mental Health Ideology in Victoria', p. 39.

20. Milton Lewis, *Managing Madness: Psychiatry and Society in Australia 1788–1980*, Australian Government Publishing Services, Canberra, 1988, p. 99.

21. *ibid.*

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