

*'Eccentric and Idiosyncratic  
Treatment Philosophies':  
The Therapeutic Community  
at Townsville's Ward 10B,  
Queensland, 1973–87*

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IN 1973, A PSYCHIATRIC UNIT KNOWN AS WARD 10B WAS ESTABLISHED AS a therapeutic community at Townsville General Hospital, Queensland. Established, in part, to avoid some of the problems that had been exposed in psychiatric treatment during the era of deinstitutionalisation, it was particularly aimed at eradicating abuses that had developed in many places as a result of institutional culture. In spite of these goals, patients at Ward 10B suffered abuses similar to those experienced by patients in more traditional psychiatric institutions in Australia. This article examines the failure of the therapeutic community at Townsville and the subsequent Queensland government commission of inquiry into the ward held in 1991. It argues that although certain problems identified by this inquiry were specific to the unit, others were common to psychiatric practice in Australia during the second half of the twentieth century. Thus, the case of Ward 10B has broader implications for the history of psychiatric treatments and therapies in Australia after 1960.

The article focuses on the experience of patients and staff at Ward 10B, as documented at the 1991 inquiry, and as recounted to various sources during the early 1990s. Although there are methodological problems inherent in using material that was not recorded at the time, this approach was chosen for two reasons. First, the later material is some of the only evidence available that reveals the experiences of patients and staff, an important aspect of this examination. Evidence at the inquiry was reconstructed from ward records, and from interviews with former staff members and other professionals associated with the unit.<sup>1</sup> Secondly, the use of this later evidence allows the author to investigate the incident as an aspect of the history of psychiatric treatments in Australia during the twentieth century.

The history of psychiatric practice in Australia has been punctuated by short-lived periods of public concern about mental health care.<sup>2</sup> The

inquiry into Ward 10B occurred during such a period of public interest, as indicated by media exposés and a series of inquiries into Australian psychiatric institutions, culminating in 1993 with the release of the report of the National Inquiry into the Human Rights of People with Mental Illness, known as the Burdekin report.<sup>3</sup> This interest was distinguished from earlier manifestations in that it concentrated upon a new discourse of patients' rights.

The process of institutionalisation must be considered in order to explain why patients at Townsville were apparently unable to protect themselves from violations of their rights. In 1961, Erving Goffman developed the concept of 'total institutions', claiming that inmates of such institutions have their autonomy completely eroded.<sup>4</sup> He argued that within a total institution, supervision is conducted by personnel whose chief activity becomes surveillance.<sup>5</sup> A basic split thus develops between the large group of inmates and the small group of staff, with each group seeing the other in terms of hostile stereotypes. The inmates are not allowed access to knowledge about themselves, and their autonomy is weakened.<sup>6</sup> However, there have been various criticisms of Goffman's conception of total institutions, primarily that Goffman overextended his definition, and overemphasised the extent to which rules constrain behaviour.<sup>7</sup> In the case of psychiatric patients, erosion of autonomy due to the process of institutionalisation is more pronounced, as in many cases their judgment is called into question simply by the nature of their illness. Nevertheless, it is important to note that resistance and agency is possible in the majority of situations.

Since the 1960s, government policy on psychiatric patients has increasingly become focused on the closure of psychiatric units, and care in the community.<sup>8</sup> These policies were a reaction to the problems of institutional culture, which had come under particularly close scrutiny during the 1960s.<sup>9</sup> In Australia, deinstitutionalisation has been promoted as a policy by successive governments at both a Federal and State level.<sup>10</sup> The development of the therapeutic community as a psychiatric treatment modality occurred during this time period, and reflected prevalent concerns about institutional abuse. This treatment method aimed to minimise the distance between staff and patients, and used group pressure to conform to modify patients' behaviour.<sup>11</sup> The therapeutic community was a popular treatment modality within psychiatry in the 1950s and 1960s, and was seen as cost and time effective.<sup>12</sup> Its popularity was, in part, due to medical and social trends, particularly the 'antipsychiatry' movement which argued that mental illness had a social basis. Therapeutic communities proved most successful in treating behavioural problems such as drug addiction.<sup>13</sup> However, by the 1970s it was largely accepted that they were unsuitable for the treatment of severe mental illnesses like schizophrenia.<sup>14</sup>

Ward 10B was established under the direction of Dr Ian Atkinson, the psychiatric supervisor for North Queensland,<sup>15</sup> who was determined that the new ward be set up as a therapeutic community.<sup>16</sup> He hired Dr John Lindsay, another doctor committed to therapeutic community principles, as director of the unit. Atkinson and Lindsay genuinely believed that their method of treatment was among the best available at that time, as well as being cost effective.<sup>17</sup> The establishment and functioning of Ward 10B, however, were compromised by a number of factors, some specific to the unit and others common to the experience of psychiatric treatment in Australia. Ward 10B was unusual both in the sense that the Townsville therapeutic community was instituted to combat problems of institutionalisation, and in the personalities of its directors. But in other respects the problems evident at the unit were far from unique. It is important to note that from the outset the psychiatric unit at Townsville was critically understaffed. This was a major cause of problems at the unit, as it was at many psychiatric institutions in Australia.<sup>18</sup> Milton Lewis argues that the policy of deinstitutionalisation presaged a period of neglect in mental health, as it led to tighter control on mental health expenditure.<sup>19</sup>

Complaints about Ward 10B began in 1975.<sup>20</sup> Thus, it is clear that there were concerns with treatment at the ward almost from its inception, although undoubtedly these concerns increased substantially by the mid-1980s, with 123 complaints made to the Hospitals Board by 1986.<sup>21</sup> Despite this, the end of the therapeutic community at Ward 10B was not primarily the result of professional or public opposition, but rather due to Lindsay's retirement from ill health in 1985. After his departure the ward was even more understaffed, which exacerbated existing problems. The increase in complaints at this time can be partly attributed to the fact that Lindsay's retirement made problems at the ward more evident, and partly to a social climate in which psychiatric treatment was more thoroughly scrutinised. The therapeutic community continued until the appointment of Dr Johann Schioldann-Nielsen as Lindsay's successor in May 1987. The appointment created tensions in the ward, where many of the staff were still committed to therapeutic community principles.<sup>22</sup> Thus, although Schioldann-Nielsen succeeded in dismantling the therapeutic community, the pressure placed upon him by other staff members led to his resignation in February 1988.<sup>23</sup>

In 1991, the Queensland government established a commission of inquiry and appointed W. J. Carter, a retired judge, as commissioner.<sup>24</sup> The inquiry found that patients at Ward 10B were subjected to verbal and physical abuse, and faced severe restrictions on their civil liberties and loss of autonomy because of the rigid application of therapeutic community principles to all patients without regard for their

circumstances. Ward policy dictated that 'no one is allowed to be an individual'.<sup>25</sup> Despite the fact that therapeutic communities were based on a social model of mental illness, patients were treated with large doses of drugs, often as a management tool.<sup>26</sup> In a staff discussion in 1986, Dr Bevan Cant, Lindsay's registrar, recorded that it was ward policy not to tie people in chairs, but to 'dope them out so much they don't move'.<sup>27</sup> This was in contrast to the principles of the therapeutic community, and is ironic in view of the fact that it was the rapid development of psychopharmacology in the 1950s that spurred the process of deinstitutionalisation in the postwar period.<sup>28</sup>

The case of P31, documented at the 1991 inquiry, provides an example of the consequences of applying therapeutic community principles to a patient suffering from severe mental illness. P31 was a psychotic patient who was also dying of acute brain syndrome.<sup>29</sup> On 23 February 1987, one of the doctors at the unit noted in her file that she reported feeling alone and was terrified of dying.<sup>30</sup> In spite of this she was still required to attend daily group meetings. One day, because she had been screaming all morning, the staff psychologist moved that the patient would only be allowed to speak in the group if she spoke 'in a high [pitched] voice', which she refused to do.<sup>31</sup> This was typical of group therapy at the ward. Decisions about patient care were put to a group vote and carried out immediately. Cant stated that patients at the unit should face an 'atmosphere of continual anxiety' in order to develop coping skills.<sup>32</sup> Later, this patient's impending death from acute brain syndrome became the focus of group attention, and she was expected to discuss it even though, according to an entry in her file, she 'had great difficulty talking about her own death'.<sup>33</sup> She died in the ward in April 1987.<sup>34</sup>

Commissioner Carter later described the treatment of this patient as 'cruel and inhumane'.<sup>35</sup> However, it must be borne in mind that as Carter's judgment was made considerably after the fact, and psychiatric treatments are subject to change, caution is essential in applying retrospective judgments. It is also apparent that staff were following procedure in the treatment of this patient. Nevertheless, it is also clear that this patient suffered unnecessary distress as a result of her treatment. Such a case provides an example of the way in which the application of certain principles of treatment without regard for individual circumstances can lead to abuse.

Although this case was particularly bad, it was not an isolated or sensational example.<sup>36</sup> Carter identified sixty-five deaths in connection with the unit that were relevant to the commission:<sup>37</sup> thirty-five patients who died by suicide or suspected suicide and thirty who died from a medical condition, most either in the ward or within a month after their final contact with it.<sup>38</sup> Furthermore, many ex-patients experienced

long-term physical and emotional suffering caused by their treatment at Ward 10B.<sup>39</sup> Carter stated at the inquiry that:

The mentally ill population deserve expert care, compassion and solicitude, not abusive and rude confrontation and above all they deserve to be spared from the excesses of those who would wish to impose upon them their eccentric and idiosyncratic treatment philosophies.<sup>40</sup>

Carter's statement indicated that the problems at Ward 10B could be attributed to the pursuit of particular treatment methods by a particular psychiatrist, and was thus a problem specific to the unit. In this respect, an examination of Lindsay's motives in adopting this treatment is relevant.

Lindsay first became interested in the principles that later formed the basis of his treatment philosophy while working overseas in the 1950s. In England he met Maxwell Jones, whose ideas on the therapeutic community influenced him greatly.<sup>41</sup> Lindsay's interest in the therapeutic community was matched by his interest in family therapy, and he combined the two at Townsville.<sup>42</sup> He claimed that his motivation for accepting the post as director of Ward 10B was the anticipation of a challenge;<sup>43</sup> a challenge not only to combine the therapeutic community with family therapy, but also to apply the principles of the therapeutic community to certified patients as well as to voluntary ones.<sup>44</sup> The application of these principles to non-voluntary patients, however, was contrary to the basic philosophy of the therapeutic community as it was originally conceived.<sup>45</sup> Lindsay adopted practices that were considered somewhat outdated, but he claimed innovation in his combination of two different therapies and in his desire to push these therapies beyond their previous boundaries.

Although this suggests that problems at Townsville can be attributed to Lindsay's desire for innovation, and refusal to recognise mistakes, further investigation reveals that this is not an unusual problem within psychiatric practice in Australia. Psychiatry has historically been more susceptible to certain problems than other medical specialties due to the result of an ongoing debate within psychiatry in regard to the causes of mental illness.<sup>46</sup> Psychiatry developed relatively late as a medical specialty, and debate over whether mental illness is, in fact, a biologically caused disease has frequently hindered its claims to scientific status.<sup>47</sup> The result has been a particular defensiveness within psychiatry, which in turn has led to an unusually high value being placed on innovation in treatments.<sup>48</sup> These insecurities within psychiatry became more apparent during the second half of the twentieth century because of renewed criticism at this time.<sup>49</sup> A pattern of pursuit of innovation, combined with a reluctance to recognise problems either potential or

actual, characterised the adoption of the therapeutic community at Ward 10B under Lindsay's direction. In the period that the ward was established, psychiatry had become more integrated with general medicine, and there was much more emphasis on biomedical models of mental illness.<sup>50</sup> Treatment at Ward 10B reflected this in the drugs administered to patients, but was in opposition to it in its use of therapeutic community principles to treat all patients, even those suffering from acute psychoses.

A patient at Ward 10B remembered that two doctors at the unit, presumably Lindsay and Cant, were seen as 'gurus... No one could question their ethics. They were accountable to no one.'<sup>51</sup> The patient recalled that the rest of the staff appeared to believe that the two were brilliant and that they were leading a revolution in mental health. However, s/he felt that the patients 'were the guinea pigs, whether we liked it or not'.<sup>52</sup> The adherence to a particular treatment philosophy despite evidence that it was not effective was a common problem within psychiatric treatment in Australia, although the problem was exacerbated by the personalities of the staff at Ward 10B. This patient's statement further reveals that a disregard for patients' opinions about their treatment was also a major problem. These circumstances were made worse by the prevalence in the general community of prejudice towards, and ignorance about, mental patients.

A lack of respect for patients' rights was a major problem at Townsville, and produced a great deal of suffering. Many incidents were documented at the Queensland inquiry. Carter noted that:

The mentally ill patient population in the general community and their relatives have had to suffer the ignorance, apathy, lack of concern, lack of respect and even, in some cases, outright rejection by a society which generally has regarded the mentally ill as worthless rejects who had to be separated from those more fortunate members of the society not so afflicted... It must be understood that a mentally ill person possesses the same dignity as any other human person.<sup>53</sup>

Many patients, even those who had had traumatic experiences there, returned to Ward 10B for treatment. This may have partly been because of the geographic isolation of the unit, which led to a lack of choice for people in the region who needed psychiatric treatment. It was also, however, a result of the stigmatisation and self-doubt faced by large numbers of psychiatric patients, which made it difficult for them to complain of violations of their rights, and which meant that their complaints were frequently not believed.<sup>54</sup>

It is necessary to contextualise these experiences with reference to the more general experience of those suffering from mental illness.

Carter's statement is borne out by a large number of studies, both Australian and international, which reveal the prejudice faced by psychiatric patients on a daily basis. In 1993, the Burdekin report estimated that around one in five adults in Australia suffered from some form of mental disorder, but that only about 3 per cent of this number sought help.<sup>55</sup> Burdekin suggested that this was a reflection of the level of ignorance about, and discrimination against, mental illness which existed in the general community.<sup>56</sup> At the end of his research, Burdekin concluded that the level of understanding of mental illness in the general community was 'abysmal'. He also stated that the media were partly to blame for this situation.<sup>57</sup> Content analysis studies of the media, undertaken in the 1980s and 1990s both in Australia and overseas, demonstrated that reportage of mental illness often encouraged stereotypes and fear of psychiatric patients.<sup>58</sup> Although, as will be seen, the role of the media in the Townsville case was largely positive, the general picture of ignorance about mental illness is relevant to the experiences of patients at Ward 10B.

Patients remembered the feelings of helplessness experienced during their time at the unit. One woman returned to Ward 10B for treatment for months, despite the fact that her mental state was not improving and she had been made physically ill by the drugs given to her there. She finally decided to seek help elsewhere:

It may seem a long time, to those who have not suffered, to come to such a decision, but it is not so to those who have suffered. Your belief in yourself, your thoughts, your own credibility with yourself is in doubt. You lose the ability to decide what is reasonable and unreasonable. And... you just simply cannot believe... that medical professionals just don't know what they are doing with your illness.<sup>59</sup>

This statement reflects not only the paralysing self-doubt felt by many psychiatric patients, but also a faith in medical knowledge that prevents many patients from resisting treatment.

Medical knowledge is given a large amount of prestige within the general community, which leads to a certain degree of disempowerment in the relationship between physician and patient. Furthermore, the nature of psychiatric knowledge, in that it deals with the workings of the mind, means that the power relationship between psychiatrist and patient is particularly problematic. The Burdekin report found that disempowerment of the patient was inherent in the relationship between psychiatrist and patient.<sup>60</sup> The powerlessness of patients is further increased by the medical hegemony model, which is based on the premise that the physician has supremacy in the hierarchy of a hospital.<sup>61</sup> The patient, at the bottom of the hierarchy, is

often disregarded. This is a particular problem in psychiatric hospitals where patients are often non-voluntary, as was the case at Townsville.<sup>62</sup> In addition, the medical hegemony model means that nurses and administrative staff in psychiatric facilities generally have little power in comparison to psychiatrists. Thus, resident medical officers at Ward 10B expressed their concerns with great hesitation, which was justified by the fact that they were ignored by those above them in the hierarchy.<sup>63</sup> Carter identified twelve 'leading figures' among the staff, in addition to Lindsay, who supported the treatment modality in place there.<sup>64</sup>

A former patient recalls an incident that illustrated the effect of the disempowerment of patients. Interrogated as a case study by a number of doctors at the unit, he was afraid he would be punished if he did not answer their questions in the right way.<sup>65</sup> When the doctors left for afternoon tea they did not tell him he could leave, so he remained sitting alone in the room until a nurse came and told him it would be alright for him to go. Even then, he felt a real threat of punishment having seen patients severely disciplined for 'much lesser misdemeanours'. He 'lived in fear' for the next few days, afraid that the doctor would punish him for leaving without his permission. He stated:

If this sounds unreal to those who don't know about life in a psychiatric ward, well, I can't help that. It will be very real for those who have. It's just the way it is when one bunch of people has total control and power over another bunch of people. We just happened to be in the bunch that had no control.<sup>66</sup>

This absolute subjection has been identified as a product of power relationships within institutions, and a major reason why patients did not resist treatment that was clearly harmful.<sup>67</sup> Although research has demonstrated the limitations of this conception of subjection, it is apparent that this patient felt quite powerless.<sup>68</sup>

The functioning of the therapeutic community at Ward 10B was intended to overcome, to some extent, problems of medical hegemony. There were attempts to break down the barriers between staff and patients; for example, the staff did not wear uniforms.<sup>69</sup> In a television interview with *60 Minutes* in 1988, Bevan Cant said that visitors to the ward could not tell the difference between the doctors and the patients as everyone looked normal.<sup>70</sup> The success of this attempt at breaking down the barriers is best illustrated with reference to the process of group therapy. The single biggest cause of tension between patients, relatives and staff,<sup>71</sup> group therapy was always confrontational and occasionally violent.<sup>72</sup> All patients, no matter what their situation or how heavily medicated, were required to attend the daily meeting.<sup>73</sup>

During these meetings, the language and behaviour of the staff towards the patients was often abusive.<sup>74</sup>

Several incidents of violent confrontation between staff and patients were documented at the inquiry.<sup>75</sup> In one session, Cant ridiculed the religious beliefs of a middle-aged woman who was heavily sedated and lying on the floor.<sup>76</sup> In another, Lindsay responded to a patient's abuse by telling him, 'I think you're a mother fucker'.<sup>77</sup> When questioned about this incident at the commission, Lindsay did not appear to think anything was wrong with such behaviour, and denied that he had said it in anger.<sup>78</sup> Lindsay claimed it was a scientific exercise to see what sort of conflict the patient could tolerate, since his mother would not respond to him when he swore at her. This case is interesting because, like the majority documented at the inquiry, it was recorded in great detail.<sup>79</sup> It is clear that the staff did not believe their behaviour and treatment methods were questionable.

Lindsay himself did not at any stage accept that his treatments were ineffective or that they were causing patients unnecessary suffering. He published a large number of articles in professional journals, all of which claimed that the therapeutic community at Townsville was a success. His last article appeared in the *International Journal of Therapeutic Communities* in 1986. In it, Lindsay discussed the existence of problems in relationships between those working at the psychiatric ward and other doctors in the hospital, but made no reference to any problems related to patients' acceptance of the treatment.<sup>80</sup> The publication of this article came at a time when many already had serious doubts about the therapeutic community at Townsville, but Lindsay acknowledged none of these doubts in his article. In 1992, he published a book entitled *Ward 10B: The Deadly Witch-Hunt*, in which he depicted himself as the victim of a hysterical campaign. Lindsay believed the campaign against him was driven by the unnecessarily vindictive mother of a former patient, by the media, for its sensationalist value, and by politicians, for political capital.<sup>81</sup>

Cant also supported the therapeutic community at Ward 10B, and gave several interviews defending the treatment methods followed there. He told *60 Minutes* that critics of the ward should have 'honoured and respected the work we were doing', and declared on ABC Radio that those who claimed that psychotherapy was not effective with psychotic patients were wrong.<sup>82</sup> In response to a question in the *60 Minutes* interview about whether treatment at the ward was ethical, he replied, 'Ethical? We're talking about cure here. And you're talking a different language.'<sup>83</sup> Other staff at the unit also continued to believe that therapeutic community methods were both revolutionary and effective, as indicated by the strong resistance to attempted reforms within the unit in the late 1980s.<sup>84</sup> The staff's adherence to these treat-

ments, combined with the refusal of both Lindsay and Cant to admit that there were any problems with the unit, reflects an immense divide in the perceptions of patients and staff at Ward 10B.

The ward at Townsville was based on a premise of complete openness, and group therapy sessions were characterised by a lack of privacy and confidentiality.<sup>85</sup> Cant boasted that ward procedures broke 'the confidentiality ethos of general medicine', and fought 'social phobia' and the 'psychiatric disease' of privacy.<sup>86</sup> However, Lindsay and Cant would leave the group if a patient's relatives persisted in asking what they perceived as 'irrelevant' questions, that is, questions about the patient's treatment.<sup>87</sup> The advocated openness was initiated only by doctors, and only in certain situations. Outside those situations, doctors and other staff refused to talk to patients or their families. Patients were not told why they were being treated as they were; they were expected to work it out for themselves as part of the 'healing' process. This expectation, however, merely increased patients' confusion and anxiety. Thus, while the treatment philosophy of Ward 10B was the opposite of many more traditional psychiatric institutions, and although the details of the problems were very different, the basis was similar: patients did not have rights.

The first written complaint about the ward was made by the father of a patient on 26 February 1975.<sup>88</sup> This was followed by other complaints throughout that year, both written and spoken. The majority were from family members and related to a lack of information about the process of group therapy.<sup>89</sup> On 16 February 1978, a patient made a written complaint to the medical superintendent, Dr Cole.<sup>90</sup> The manner in which the hospital dealt with this complaint illustrates the failure of the system to respond adequately to the concerns of patients. Cole raised the matter with Lindsay. Lindsay subsequently addressed the patient in front of the group. The patient's concerns were ignored or criticised. Lindsay told him that he could leave if wanted to, but if he did to 'keep on walking'.<sup>91</sup> Lindsay's excuse for this behaviour—that the complaint had breached the confidentiality of the group therapy process—is somewhat ironic in view of Cant's contempt for medical confidentiality.<sup>92</sup> Such conduct was common,<sup>93</sup> however, and complaints about Lindsay's behaviour and treatment methods continued throughout the 1980s, but no action was ever taken.<sup>94</sup>

Due to the failure of institutional systems of review to provide an adequate response to complainants, many of those involved with the ward were compelled to take their grievances to the media. Queensland newspapers the *Courier Mail* and the *Townsville Bulletin* were instrumental in exposing problems at Ward 10B, at least during the late 1980s.<sup>95</sup> At the same time, and reflecting a similar social climate of scrutiny of psychiatric treatment and emphasis on patients' rights,

Townsville victims established an action group. Community and media sources urged the establishment of an inquiry into Ward 10B, despite government reluctance to do so.<sup>96</sup> It is likely that the Queensland inquiry would never have been established if not for the efforts of former patients and the media.

The government inquiry into Townsville General Hospital's Ward 10B highlighted certain problems in psychiatric treatment, and inadequacies in medical and government institutions. That these were common to many Australian psychiatric institutions was indicated by the report of the National Inquiry into the Human Rights of People with Mental Illness released in 1993. It was partly as a result of the Queensland report that a national inquiry was considered necessary. One of the conclusions of the national inquiry was that deinstitutionalisation had not proved to be a successful policy.<sup>97</sup> The report blamed this partly on the failure of the government to provide adequate funding, redirected from psychiatric institutions, for community-based centres.<sup>98</sup> Governments in the 1990s continued to endorse the policies of deinstitutionalisation and mainstreaming. In a 1994 initiative in response to the Burdekin report, the Federal government stated that it was attempting to address problems with these processes by improving inter-professional links and redirecting resources to community services.<sup>99</sup>

At the Queensland inquiry, Carter argued that:

The primary lesson to be learned from the findings of this Commission of Inquiry is that what happened in Ward 10B between March, 1975 and May, 1987 must never be allowed to be repeated in this or in any other psychiatric unit.<sup>100</sup>

The terms of reference of the Queensland inquiry, however, hampered it from making a long-term contribution to mental health reform. Early 1990s reforms were the result of government initiatives undertaken in the context of concerns about mental health and a national push from consumer bodies at the time, rather than the findings of specific inquiries. This raises the question of whether such inquiries are really necessary, although the Queensland inquiry did serve a useful purpose in restoring community confidence in the only public psychiatric ward in the area.<sup>101</sup> For a long time, however, many people were reluctant to seek help there, in spite of the reforms that had already taken place.<sup>102</sup>

Despite the multitude of inquiries into psychiatric institutions that were carried out in the twentieth century, the national inquiry of 1993 was the first to focus on the rights of patients.<sup>103</sup> As such, it represented a conceptual leap in the treatment of patients with a mental illness. Under the National Mental Health Strategy, endorsed in 1992, the Federal government undertook a four-year campaign to raise public

awareness on the subject of mental illness. However, government documents from the mid-1990s indicate that this campaign was much less successful than had been anticipated.<sup>104</sup> Many of those working in the area of mental health argued that it was discrimination and prejudice against those suffering from mental illness, rather than any specific government policy, that formed the basis of problems faced by psychiatric patients.<sup>105</sup> Lack of adequate funding was also a consistent problem in the provision of mental health care for most of the past century, a problem that appears to be continuing today.<sup>106</sup> Reforms in psychiatric treatments since the 1960s have had an enormous impact on the practice of psychiatry, and have led to revolutionary new treatment methods, one of which was the therapeutic community. But as the case of Townsville General Hospital's Ward 10B shows these new treatment methods were not sufficient in themselves to eradicate the problem of abuses of patients' rights.

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1. Queensland Commission of Inquiry into the Care and Treatment of Patients in the Psychiatric Unit of the Townsville General Hospital, *Report*, (W. J. Carter, Commissioner), Government Printer, Brisbane, 1991, 3.4, 3.8, 3.10.

2. Milton Lewis, *Managing Madness: Psychiatry and Society in Australia 1788–1980*, Australian Government Publishing Service (AGPS), Canberra, 1988, p. xi. See also Raymond Evans, *Charitable Institutions of the Queensland Government to 1919*, MA thesis, University of Queensland, 1969.

3. For a list of inquiries during this period, see 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* (hereafter *National Inquiry*), Brian Burdekin, Commissioner, AGPS, Canberra, 1993, pp. 17–19. See also Peter Barham, 'Foucault and the Psychiatric Practitioner', in Arthur Still & Irving Velody, (eds), *Rewriting the History of Madness: Studies in Foucault's Histoire de la Folie*, Routledge, London, 1992, p. 47.

4. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, Penguin Books, Harmondsworth, 1968 (1st pub. 1961), p. 15.

5. *ibid.*, p. 18.

6. *ibid.*, p. 19.

7. Philip Manning, *Erving Goffman and Modern Sociology*, Polity Press, Cambridge, 1992, pp. 115, 157–8; Nick Perry, 'The Two Cultures and the Total Institution', *British Journal of Sociology*, vol. 25, 1974, pp. 345–55; Andrew Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective*, University of California Press, Berkeley, 1989, pp. 309–10.

8. Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present*, Harper Collins, London, 1997, p. 521.

9. Robert Castel, Francoise Castel & Anne Lovell, *The Psychiatric Society*, Columbia University Press, New York, 1979, p. 231; Scull, *Social Order/Mental Disorder*, p. 310.

10. Lewis, *Managing Madness*, p. 98.

11. Porter, *The Greatest Benefit to Mankind*, p. 522.

12. *Psychiatry Gone Crazy* (sound recording), ABC Radio, Sydney, 1991; Australian Health Information and Research Service, *Mental Illness*, Seymour, Sydney, 196–, p. 7.

13. Castel, *et al.*, *The Psychiatric Society*, pp. 192–4.

14. Michael H. Stone, *Healing the Mind: A History of Psychiatry from Antiquity to the Present*, W. W. Norton, New York, 1997, p. 216. See also Peter A. Newcombe, 'Potential Benefits and Positive Consequences', *Bulletin of the Australian Psychological Society*, vol. 13, no. 5, 1991, p. 5.

15. Queensland Commission of Inquiry, *Report*, 7.2.
16. *ibid.*, 7.3, 7.5, 7.6.
17. *ibid.*, 7.8.
18. John S. B. Lindsay, *Ward 10B: The Deadly Witch-hunt*, Wileman Publications, Main Beach, Qld, 1992, pp. 68–74; *National Inquiry*, p. 238. These problems were not confined to Australia. See Warwick Brunton, ‘Colonies for the Mind: The historical context of services for forensic psychiatry in New Zealand’, in Warren Brookbanks (ed.), *Psychiatry and the Law: Clinical and Legal Issues*, Brooker’s, Wellington, 1996, pp. 18–19.
19. Lewis, *Managing Madness*, p. 98.
20. Queensland Commission of Inquiry, *Report*, 11.17.
21. *ibid.*, 11.7.
22. *ibid.*, 7.46.
23. *ibid.*, 7.47. Carter identified four staff members in particular who opposed Schioldann-Nielsen. These staff members had worked at the ward for varying time periods. See Queensland Commission of Inquiry, *Report*, Finding 95, 13.1, 13.2.
24. Geoffrey Hawker, ‘Inquiries into Policy Communities: Townsville and Chelmsford’, in Patrick Weller (ed.), *Royal Commissions and the Making of Public Policy*, MacMillan Education Australia, Melbourne, 1994, p. 96.
25. Queensland Commission of Inquiry, *Report*, 7.22. This was standard for therapeutic communities; see Castel, *et al.*, *The Psychiatric Society*, p. 194.
26. Queensland Commission of Inquiry, *Report*, Finding 44.
27. *ibid.*, 7.22.
28. Porter, *The Greatest Benefit to Mankind*, p. 521.
29. Queensland Commission of Inquiry, *Report*, 9.3.138.
30. *ibid.*, 9.3.139.
31. *ibid.*, 9.3.140, 9.3.141.
32. *ibid.*, 7.20.
33. *ibid.*, 9.3.49–9.3.50.
34. *ibid.*, 9.3.143.
35. *ibid.*, 9.3.145.
36. In the course of the inquiry, 200 cases out of over 1000 were selected for closer examination; they were not selected randomly. See Queensland Commission of Inquiry, *Report*, 3.14, 3.15.
37. *ibid.*, 10.18.
38. *ibid.*, 10.19. Of the suicides, 27 were definite suicides who definitely had contact with the ward; the rest are doubtful in some respect (10.21).
39. For many examples, see Philip Mildenhall & Emma Pierce, *A Place of Safety*, P. E. Pierce, Sydney, 2000.
40. Queensland Commission of Inquiry, *Report*, 20.5.
41. *ibid.*, 5.7.
42. *ibid.*, 5.10, 5.22.
43. *ibid.*, 5.23.
44. *ibid.*, 5.23, 5.27.
45. Christine Alavi & John Frow, ‘Firm Judgments on Uncertain Issues’, *Australian Society*, August 1991, p. 19.
46. Mark S. Micale & Roy Porter (eds), *Discovering the History of Psychiatry*, Oxford University Press, New York, 1994, p. 5.
47. Porter, *The Greatest Benefit to Mankind*, p. 493; Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, Jose Barchilon (trans.), Vintage Books, New York, 1965, p. x.
48. Michael Wearing, ‘Professional Discourse and Sensational Journalism: Media constructions of violent insanity’, *Australian Journal of Communication*, vol. 20, no. 1, 1993, p. 88.
49. Castel, *et al.*, *The Psychiatric Society*, pp. 217–18. These criticisms did not, of course, originate at this time (Brunton, ‘Colonies for the Mind’, p. 20).
50. Stone, *Healing the Mind*, p. 239.
51. Mildenhall & Pierce, *A Place of Safety*, p. 62.
52. *ibid.*
53. Queensland Commission of Inquiry, *Report*, 1.7, 1.10.

54. *National Inquiry*, p. 913; Ellis Hopper, 'Hospitals, Health and Politics', *National Healthcare*, Summer 1994, p. 23.
55. *National Inquiry*, p. 14; *The State of Mental Health Care in Australia* (sound recording), ABC Radio, Sydney, 1989.
56. *National Inquiry*, p. 4.
57. *ibid.*, pp. 199–200.
58. Matthias C. Angermeyer & Herbert M. Matschinger, 'The Effect of Violent Attacks by Schizophrenic Persons on the Attitude of the Public towards the Mentally Ill', *Social Science and Medicine*, vol. 43, no. 12, 1996, p. 1721; Mike Hazelton, 'Reporting Mental Health: A discourse analysis of mental health-related news in two Australian newspapers', *Australian and New Zealand Journal of Mental Health Nursing*, vol. 6, no. 2, 1997, p. 73; Otto F. Wahl, *Media Madness: Public Images of Mental Illness*, Rutgers University, New Brunswick, 1995, pp. 11, 130; Meryl Williams & Judy Taylor, 'Mental Illness: Media perpetuation of stigma', *Contemporary Nurse*, vol. 4, no. 1, March 1995, pp. 44–6.
59. Mildenhall & Pierce, *A Place of Safety*, p. 64.
60. *National Inquiry*, pp. 256–8.
61. Margaret Tobin, 'Inquiries at Lakeside and Aradale Hospitals: Lessons and advances?', *Australian and New Zealand Journal of Psychiatry*, vol. 27, no. 2, 1993, pp. 336, 340.
62. Tobin, 'Inquiries at Lakeside and Aradale Hospitals', pp. 334–5.
63. Queensland Commission of Inquiry, *Report*, 11.37, 11.40–11.41, 11.58.
64. *ibid.*, Finding 92.
65. Mildenhall & Pierce, *A Place of Safety*, p. 78.
66. *ibid.*, p. 79.
67. Goffman, *Asylums*, p. 19.
68. Nicos P. Mouzelis, 'On Total Institutions', *Sociology*, vol. 5, 1971, pp. 113–20.
69. Queensland Commission of Inquiry, *Report*, 11.61. The medical superintendent, Dr Cole, complained of a breakdown of barriers between patients and staff in a letter written on 9 December 1988.
70. 'Ward 10B', *60 Minutes* (video recording), Channel 9, 23 October 1988.
71. Queensland Commission of Inquiry, *Report*, Finding 31.
72. Violence in psychiatric institutions is a major problem. See Thomas D. Shazer, 'Workplace Violence in a Psychiatric Facility: Estimated frequency and staff perceptions', *New Directions for Mental Health Services*, vol. 69, Spring 1996, p. 67. Hospitals where the worst problems occurred had a low staff-to-patient ratio, and were characterised by authoritarian attitudes, the under-involvement of the medical staff, poor communication among staff, and demoralisation and incompetence among staff, many of which were factors at Townsville. See also A. K. Shah, 'An Increase in Violence among Psychiatric Inpatients: Real or apparent?', *Medicine, Science and the Law*, vol. 33, no. 3, 1993, p. 228.
73. *Psychiatry Gone Crazy*, ABC Radio.
74. Queensland Commission of Inquiry, *Report*, 11.38.
75. *ibid.*, 9.6.27–9.6.51. Many of these incidents also display resistance on the behalf of patients.
76. Mildenhall & Pierce, *A Place of Safety*, pp. 49–51.
77. Queensland Commission of Inquiry, *Report*, 9.3.85.
78. *ibid.*, 9.3.38.
79. *ibid.*, 9.3.87.
80. *ibid.*, Appendix V, A12–A13.
81. Lindsay, *Ward 10B*, pp. 75–6, 109–26, 294–343.
82. 'Ward 10B', *60 Minutes*; *Psychiatry Gone Crazy*, ABC Radio.
83. 'Ward 10B', *60 Minutes*.
84. John Ellard, 'The Lessons from Townsville', *Modern Medicine*, vol. 34, no. 7, 1991, p. 35.
85. Queensland Commission of Inquiry, *Report*, 9.3.5.
86. *ibid.*, 9.1.8.
87. *ibid.*, 9.3.115.
88. *ibid.*, 11.17.
89. *ibid.*, 11.18.
90. *ibid.*, 11.19.
91. *ibid.*, 11.19.

92. *ibid.*, 11.20.
93. *ibid.*, 11.21–11.22, 11.23.
94. *ibid.*, 11.31, 11.66.
95. For example, Philip Hammond, 'Psychiatric Policies "Risky" for Patients', *Courier Mail*, 30 January 1988, p. 14.
96. 'Human Rights Inquiry Move on Ward Deaths', *Courier Mail*, 2 February, 1988, p. 2; *Psychiatry Gone Crazy*, ABC Radio.
97. Bill Tyler, 'Normalised Evils: The Burdekin Report and the dignity of the mentally ill', *Eureka Street*, vol. 3, no. 10, 1993/1994, p. 48.
98. *National Inquiry*, p. 909.
99. *Working Together: Mental Health Federal Budget Initiatives, 1994–95: Incorporating the Federal Government's Response to the Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1994, p. 16.
100. Queensland Commission of Inquiry, *Report*, 20.4.
101. Hawker, 'Inquiries into Policy Communities', pp. 98, 104.
102. Personal communication with Graeme Harris, Liaison Worker for the Schizophrenia Fellowship of Australia, Townsville Branch, 11 October 1998.
103. *National Inquiry*, p. 5.
104. *Working Together*, p. 1; Tony Wade, 'Challenging the Myths of Mental Illness', *Health Forum*, vol. 34, June 1995, p. 18.
105. Brian Burdekin, 'On the Violation of the Human Rights of the Mentally Ill', *Adelaide Voices*, April/May 1994, p. 3.
106. *Courier Mail*, 21 February 2003, p. 14.