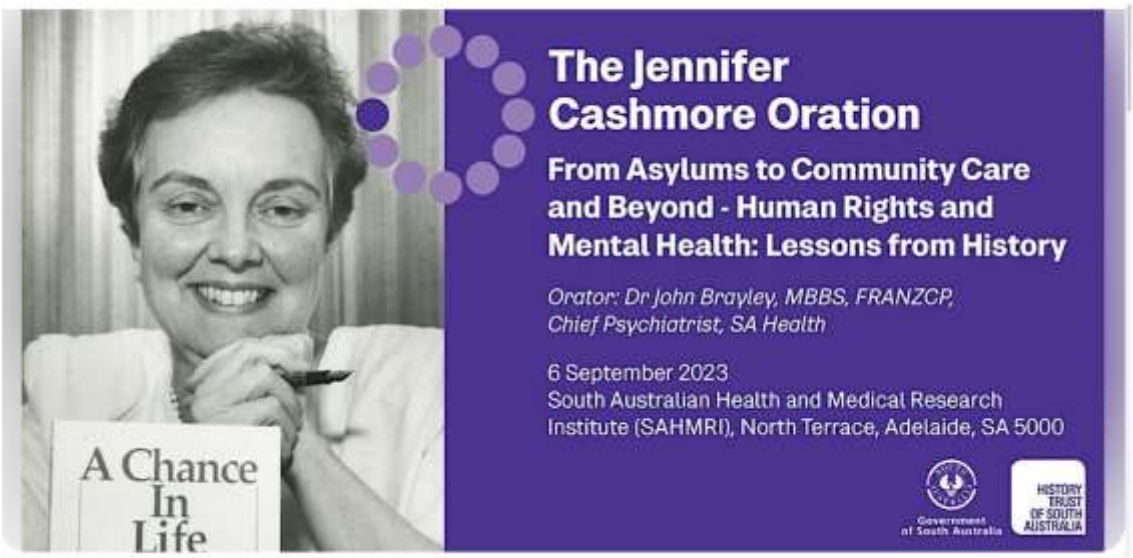

A Chance
In
Life
The Jennifer
Cashmore Oration
From Asylums to Community Care
and Beyond - Human Rights and
Mental Health: Lessons from History
Orator: Dr John Brayley, MBBS, FRANZCP,
Chief Psychiatrist, SA Health
6 September 2023
South Australian Health and Medical Research
Institute (SAHMRI), North Terrace, Adelaide, SA 5000
Government
of South Australia
HISTORY
TRUST
OF SOUTH
AUSTRALIA

We would like to acknowledge that this land we meet on today is the traditional land of the Kaurna people, and that we respect their spiritual relationship with their country. We also acknowledge that the Kaurna people are the custodians of the Kaurna land, and that their cultural and heritage beliefs are still important to the living Kaurna people today.

Before we begin, I wish to give a message about self-care. This presentation covers positive developments, but it also covers failures, abuse, and trauma. Some people here may have experienced this either in the distant past or more recently. Self-care, talking to others and, if necessary, calling a line are good to keep in mind.

South Australia's mental health system has undergone dramatic changes over the 19th, 20th and 21st Centuries. Today's presentation will cover key transition periods, and then discuss common themes.

During each epoch, new models of mental health care based on humane principles have offered an advance to many, with reforms that have been driven by science and social movements - both local and international.

However, similar patterns recur. Laudable aims are put forward, progress occurs, but, at each point in history, we can see the recurrence of problems and similar types of failures that beset earlier generations. This oration is a story of hope and progress, but it also describes failures and tragedy, and lessons that we forget at our peril, as issues recur from generation to generation.

In presenting a history such as this, it is not possible to acknowledge all those who have made a significant contribution, nor to note every key development. Instead, I wish to take examples from history to illustrate the recurring themes, as our services have moved, from prisons, to asylums and to community.

Another related topic this presentation will consider is stigma.

Before commencing with the historical discussion about mental health, I wish to provide some context to human rights.

This presentation is set in the context of our modern understanding of human rights that now drives reform, in particular the United Nations Conventions on the Rights of Persons with Disabilities (UNCRPD for short), which entered into force in Australia in 2008.

This work stems back to the Universal Declaration of Human Rights in 1948, and the two key conventions from 1966: the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights.

Examples of the social, economic, and cultural rights, the so-called positive rights include attaining the highest standard of physical and mental health, and access to housing and support for families. Examples of civil and political rights include: equality and non-discrimination, the right to self-determination, and freedom from torture or cruel, inhuman and degrading treatment.

A rights discussion in mental health involves both these positive and negative rights.

I also wish to reflect on the definition of disability.

The pre-amble to the convention has this statement:

OFFICIAL

UNCRPD

Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others,

Disability is the interaction between persons with impairments, and attitudinal and environmental barriers that hinder. Disability is not just a result of a person's mental illness. A person may have an illness or an impairment, which may, in itself be caused a by a combination of factors: life-trauma, loss, social pressures, or biological susceptibility. But the disability that person experiences, their wellbeing, whether the person can live the life worth living they aspire to or not, is constrained by barriers. Attitudinal barriers include stigma and discrimination.

A second concept is equality of all people. Historically, work for people who are mentally ill has been driven by the doing of good deeds - by charity, kindness and compassion. There can be an expectation of gratitude from recipients. Yet if a person holds rights, then care, treatment, support, and housing should be an expectation. A rights-based approach is based on equality. However, to have equality we cannot just talk about the rights of vulnerable groups - we all need to have our rights recognised so that this equality can occur.

Prisons to Asylums

Prior to the use of asylums, people with a mental illness or disability could easily be held in prison, or confined in poor houses and other places. In England- the first Therapeutic asylum was St Luke's Hospital in London opened in 1750 by William Battie. William Tuke, a philanthropist and quaker saw appalling conditions in St Luke's, and in 1796 opened the York Retreat with long and airy corridors. The development of moral treatment also stemmed from Philippe Pinel's work at the Bicetre and Salpetriere Hospitals.

Dr Philippe Pinel ordering the removal of chains from patients at the Paris Asylum for insane women.

Dr. Philippe Pinel at the Salpêtrière , 1795 by Tony Robert - Fleury. Public domain

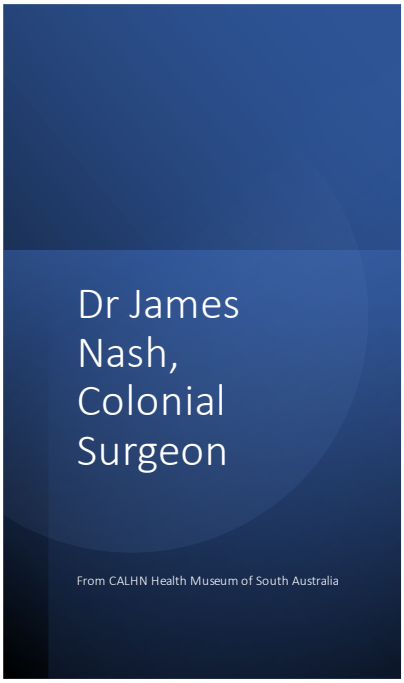
This picture is of the removal of the chains by Pinel.

Dorothea Dix

Mental Health Advocate

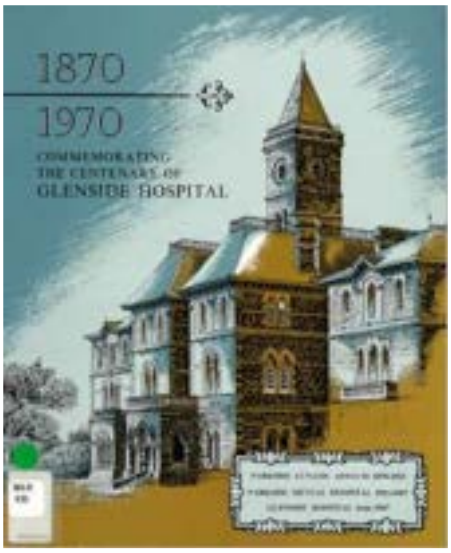
Work in new world was led by the remarkable mental health advocate Dorothea Dix who, in the 1840s and 1850s, visited prisons and alm houses in the US, where she often found people chained, cold, and poorly fed in inhumane settings. There appeared to be a misconception that people with mental illness would be oblivious to these deprivations. Her work across many states in both the North and South of the United States, in provinces in Canada, and in Scotland, led to new asylums and the reform of existing ones.

Such changes depended on extraordinary people, and, for completeness, Ms Dix's other actions are worth mention. According to biographers she most likely saved the life of Abraham Lincoln from an early assassination attempt. Through her connections in the South she learned great details of a plot to assassinate him as he travelled to Washington DC and her information triggered a lifesaving change in his railway journey. When war broke out, she was appointed Superintendent of Army Nurses in the Union Army, and during the war, her nurses looked after the injuries of Union and Confederate soldiers alike.



In South Australia, from August 1841 the mentally ill were looked after in Adelaide Gaol. The first recorded criticism of this was by Dr James Nash, the Colonial Surgeon. He was concerned that the mentally ill in the gaol were being provided prison food, and that they should receive the same rations as patients at the Adelaide Hospital. This was because they are hospital patients not prisoners.

The Sheriff at the time considered that when the insane were sent to gaol, it increased their malady: patients deeply felt the incarceration. James Nash also wrote that there were no gardens or grounds for amusement and exercise, and that the shock which patients received during lucid intervals, at finding themselves inmates, was injurious. The outcome of this was the establishment of a temporary asylum. Legal requirements were put in place – the new temporary asylum was to be gazetted for the purpose, and people moved to the asylum had to be certified, by two legally qualified medical practitioners, as being insane. In August 1846 there was an ordinance that gave new powers to Official Visitors. They were to keep minutes of their visit and had the power to discharge patients. Patients could not be concealed from Official Visitors, and it was an offence to willfully abuse, ill-treat or neglect any patient. This is very familiar – these are the same broad legal approaches we talk about today.



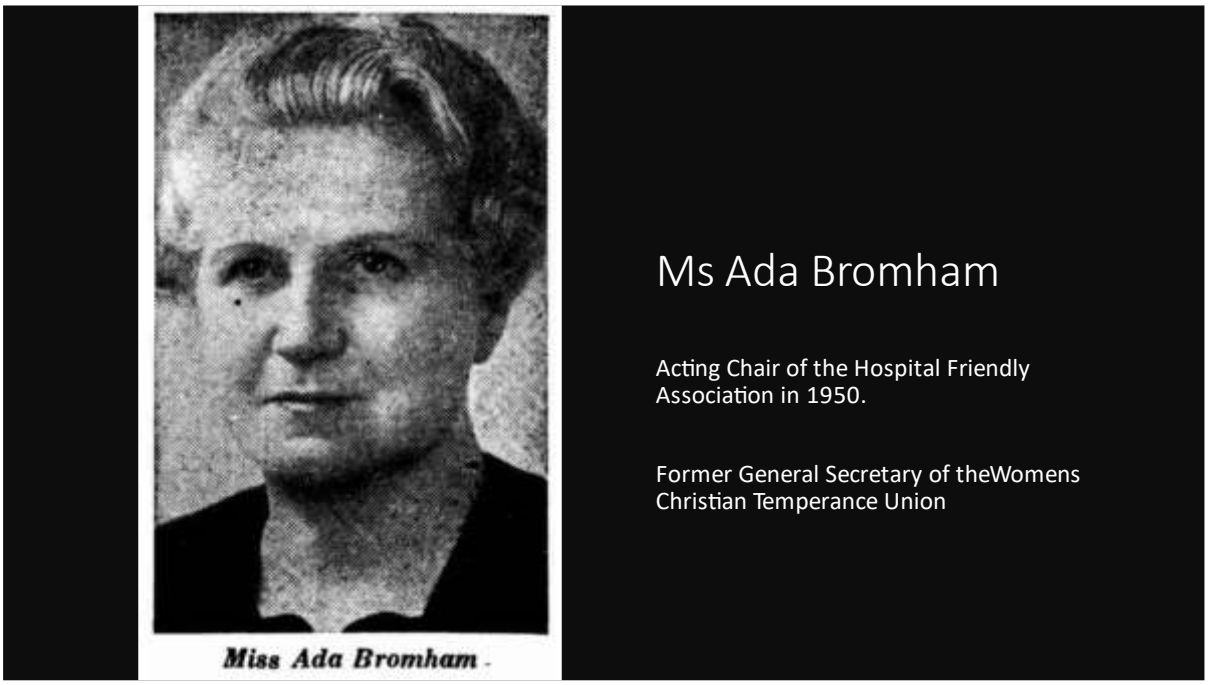
From a temporary site, in 1852, patients were transferred to the Adelaide Lunatic Asylum built on North Terrace, and then after in 1870 when the Parkside Lunatic Asylum opened, the Adelaide Asylum closed in 1902. The Enfield Receiving House, which opened in 1922, offered assessments and admission without the need for a patient to be admitted to an Asylum. Hillcrest Hospital opened in 1929.

The Asylum

The history of Glenside Hospital is well documented in this illustrated book commemorating its centenary and released in 1970.

I do not wish to go through the history of the institution here, except to refer to the later times as deinstitutionalisation developed.

The institutions were established with the noblest objectives, but through the years, and despite the goodwill of most of those who worked in the system, overcrowding of buildings, inadequate staff numbers and a lack of therapies led to poor conditions that were subject to periodic reviews.



A scan of newspapers gives an indication of the issues of the day. Ada Bromham, who was then acting Chairman of the Hospital's Friendly Association, wrote an article in The News about Parkside Hospital in 1950.

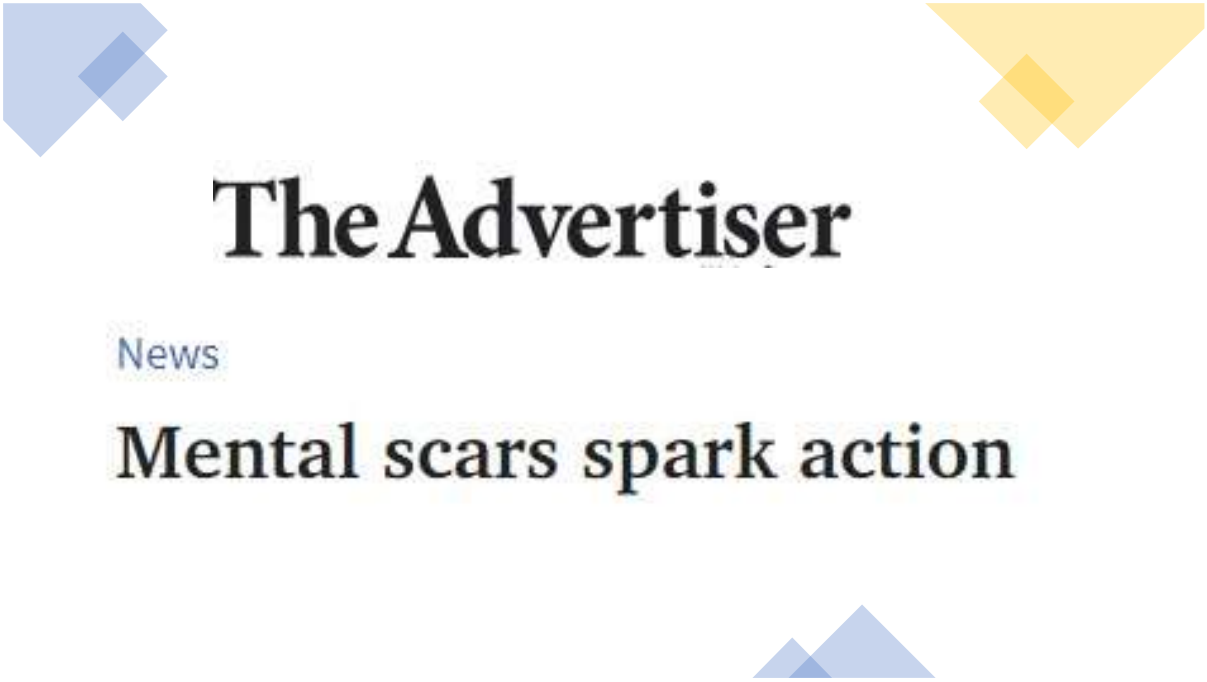
By way of further background, Miss Bromham was a leader of the Australian delegation to the 1926 International Suffrage Alliance in Paris, who worked for the welfare of Aboriginal people, was a former general secretary of the Women's Christian Temperance Union, and was active in WA, SA and Victoria.

In her News article, Miss Bromham complained that recommendations made to Minister Lyell McEwin in 1943 had not been followed through. The Superintendent, Dr Hugh Birch, had reported overcrowded buildings as the numbers of children, young people and adults swelled. Women patients were in small cells, and confined day and night without central heating. Their diet was not balanced, there were depressing exercise yards with high iron or stone walls, and a lack of segregation. Dr Birch had urged that children under 12 should not be with adult patients. The children, of course, were those with intellectual disability, as there was not a separation of people who had a mental illness from those people who had a disability. There had been some debate in the press in 1948 and 1949 between the Friendly Association, led by the Reverend J Eric Tregilgas - and with Dr Birch and the Minister - on the theme of whether the hospital was more like a gaol, but there seemed to be more in common about the recognition of the limitations of the Parkside facility.

Historic abuse in psychiatric hospitals

While the problems in SA institutions were known, it is not possible to readily identify major scandals of the extent to those exposed in other places – until Oakden. Could it be that, within the bandwidth of poorly staffed and trained institutional settings, our institutions may have been better led and monitored than other states, or is it simply that problems remained hidden?

Overall, there has been comparatively little published about this topic, possibly because the victims have been unable to raise matters, and were struggling with poor health or have been disempowered. In other places it has often depended upon staff whistle-blowers to come forward rather than patients themselves.



The Advertiser

News

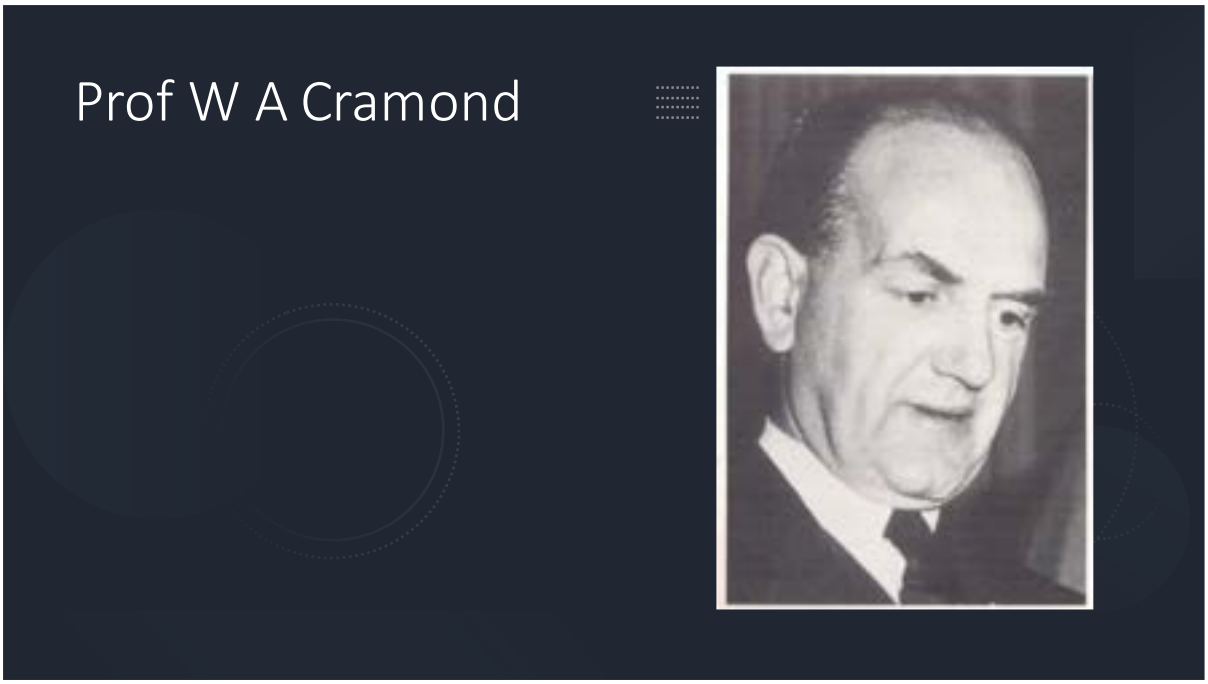
Mental scars spark action

In 2012 the Office of the Public Advocate sought to obtain information about past abuses in South Australia. A journalist, Andrew Dowdall, published an article titled “Mental Scars Spark Action” in the *Sunday Mail* and the Office put itself forward as a call-in line. Fourteen people contacted the Office. We considered this to be a significant response from one press item. When a follow-up article was published there were a further nine calls.

We received responses from people who were detained as teenagers and adults, as well as from their family members and staff, relating their experiences. The events occurred from the 1960s through to the late 1980s.

The abuse experiences reported included emotional, sexual, and physical abuse as well as neglect. A common factor was the lack of respect, lack of accurate diagnosis, and mismanagement of their needs at the time. Many reported exposure to distressing sights to which they should not have been exposed, particularly as teenagers.

Apart from abuse and neglect, we know the harmful effects of institutionalisation on many people. If disability is the response of the combination of impairments plus barriers, then being in an institution is a barrier and limitation, as seen by the improvement of most of the people who subsequently left institutions when appropriate support and care was provided.



Cramond influence

Bill Cramond had a significant reform role in SA mental health in different times over a period of three decades. He had originally graduated from Aberdeen University in Agriculture, was commissioned to the Army in 1940 and posted to India. As an acting Captain in the Gurkha Rifles, he was struck down by polio. This experience led to a career change. He studied medicine and then psychiatry. He was appointed Director of Mental Health in South Australia in 1960 and then Professor of Mental Health at the University of Adelaide between 1963 to 1971. He then had roles elsewhere but returned to SA in 1983, where he had a significant role in the development of community clinics, outreach clinics, and then, in the 1990s, was Chair of the South Australian Mental Health Services (SAMHS) between 1993 and 1995.

Some of Cramond's first recommendations described in a report to Minister Sir Lyell McEwin included: the development of outpatient services, establishing a day hospital, the development of admission wards at the hospital, reducing the size of wards, catering only for the mentally ill and providing separate facilities for people who experienced an intellectual disability, improved training for staff, addressing the need for social workers and occupational therapists amongst other recommendations - and the establishment of a separate division for forensic psychiatry. With respect to the decision to establish a separate facility at Strathmont, I recall Prof Cramond telling me once that he was influenced by a carer who was a strong advocate. The Cramond report was adopted.

The next section considers the transformation to community care that occurred in Trieste Italy. There is still much debate about how the Trieste model can or cannot be applied in other places, but Trieste does provide an example of what is possible.

Trieste 1973

Franco Basaglia was an Italian psychiatrist and a revolutionary in overturning Italy's system of asylums and creating community models.

In World War II he was an antifascist and joined the Resistance. He was then arrested and imprisoned for six months. Some biographers suggest that Basaglia's memories of imprisonment led to the intense negative reaction he had to asylums. He was driven by human rights, influenced by existential philosophers, was fond of Sartre's work, and that of Goffman about asylums.

There were many steps in this, but a key symbolic moment occurred on February 25, 1973 when four hundred patients marched out of the San Giovanni Psychiatric Hospital and out and about Trieste. The procession was headed by a large papier mâché and wooden horse, that had been given the name Marco Cavallo, made by patients, artists and clinical staff. This was the liberation of the patients, prior to the eventual closure of the asylum in 1980 and a law that would decree the end of asylums in Italy.

Basaglia set up networks of community clinics to replace the asylum. The innovation was recognised globally with mental health practitioners, including those from Australia, travelling there to see the new systems and apply learnings.

From Asylums to Community – 1980s and 1990s

The move to community

Combined with the developments in the US, UK and a successful trial of community care in Sydney, South Australia in the early 1980s was primed for the development of community clinics.

Some of the key observations made of the Trieste system are that rights have been upheld while still delivering good quality and state of the art mental health assessment and treatments. Best practice coexists with human rights. This initiative and community models influenced the development of community care in Australia delivered in the home, and in new developing residential centres.

During this period there was also common acceptance of the good care at Hillcrest Hospital in particular. One report describes Dr Norman James leading the hospital to a standard of excellence, as evidenced by Hillcrest Hospital becoming the first fully accredited psychiatric hospital in Australia.

However, concerns about the mental health system persisted through the decades with events and reviews, and the development of the South Australian Mental Health Service.

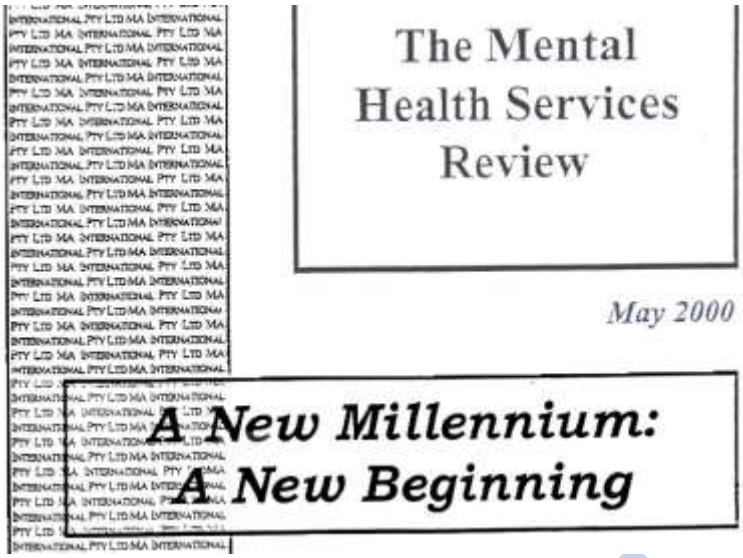
In 1992 the tragic death of a medical officer at the hands of an unwell patient at Hillcrest was seen by many staff as symptomatic of the difficulties of the service.

That doctor, Dr Nandadevi Chandraratnam, was respected and loved by colleagues and patients alike. Back then I was working elsewhere and went to Hillcrest to do Dr Chandra's clinics for a short while. It was too much to expect her bereaved colleagues to take this on. Many of the people she treated where either shocked or in a state of loss and sadness. This included people who might otherwise be preoccupied and talking about psychotic thoughts. This was a reflection on the regard in which Dr Chandra was held by per patients, but this loss also bound people together in a common grief.

That year, the CEO of SAMHS called in Prof Cramond to undertake a review as further changes proceeded.

At this point it is worth reflecting on the changes in bed numbers over time which have significantly reduced with the development of community teams and a move to local acute services. For example, a report for 1961 by the Director-General of Medical Services lists the average daily number of patients in Parkside as 1606 cases, for Northfield 848 and Enfield 59. This was a total number of 2513 beds for a South Australian population of 969,000 persons. By contrast, in 2023 we have almost 500 hospital beds across all of our hospitals and age groups, and further 120 community beds with 24 hour support for 1.8 Million people, and with a network of community services and other support services as well.

I now wish to go to the year 2000 to another review about mental health.



In May 2000 Dr Peter Brennan submitted the *Mental Health Services Reivew - A New Millennium, A New Beginning*. This review that said there were already enough reviews, and that even more reflection would be detrimental. The question of comparative resources was raised - the notion that South Australian Mental Health Services are under-resourced (ie beds, dollars, people), the reviewers said, is not supported by national comparisons. What is lacking is vision and leadership, and what was needed was a director who would implement a program that will address the priority areas. Quality and Safety will have the highest priorities.

This idea of expecting more within existing funding is an interesting concept. This is not to say that mental health does not need more resources – there are now well recognised planning tools that show the gap. However not all problems that people may experience with services can be attributed to the gap, as at any time there are services in both government and non-government sectors that excel due to vision and commitment, even though they may have a similar funding base as other services that have problems.

Dr Margaret Tobin was appointed to the Director role. She is seen in the picture above outside the SA Health Citi Centre Building on her first day at work. She had instituted significant reforms in Victorian psychiatric hospitals where patients had experienced abuse and neglect. She then led a new wave of leadership in Southeastern Sydney - some of the leaders she developed have made significant ongoing contributions in that state. Margaret was a skilled change manager. She identified where power was held and was prepared to tackle the power holders if resourcing decisions and service arrangements were being made to benefit the institution and not the community. This might be tackling the historical accumulation of doctors and nurses in one unit that left another area understaffed, or work arrangements that did not deliver the best care. She was not afraid to say things as they were, although she could be taken aback by the intensity of the responses. At the same time, she encouraged and supported both existing and new leadership, and change champions throughout services working to implement the new vision. She led the development of a series of Emergency Demand Policies that were designed to tackle many of the problems that still beset our system today.

Margaret would often make a passing remark that the solution to whatever problem was not rocket science - the evidence was there of what needed to be done, the challenge was implementation. Many of the steps to ensure people received care were simple ones, but obstacles to be overcome would get in the way.

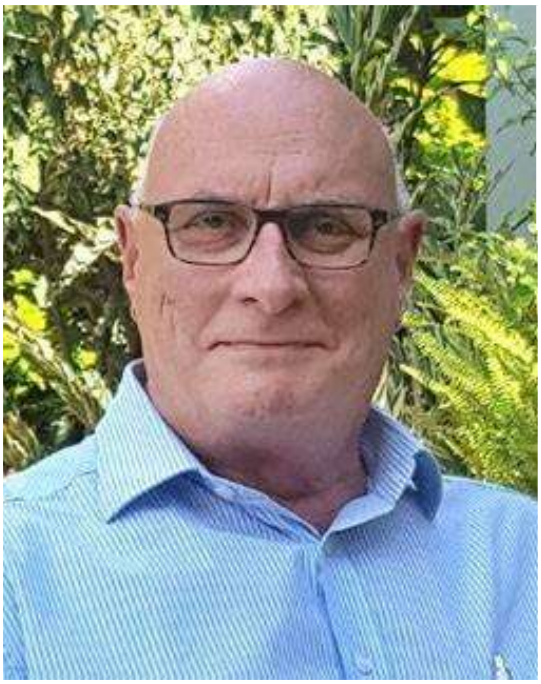
These obstacles were enormous and included a hornets nest she had stirred up at Glenside. This is all described in Melissa Sweet's 2006 book *Inside Madness*. Margaret had recruited a nurse leader, Des Graham, to manage the change at Glenside. Des had received several death threats. Another less senior nurse manager making changes at the hospital was also at risk. Staff would become silent when he walked into wards, and he had received a letter saying his days were numbered. His car was firebombed at his home. At the time the book was written no final link was concluded.

As you probably know Margaret Tobin was assassinated on level 8 in the Citi Centre Building just outside of the lifts. This was on 14 October 2002. Although suspicions were initially local, it soon became clear that a NSW psychiatrist was the suspect, and was later convicted. Her death stemmed from actions she had taken as a mental health leader in NSW. She died in the line of duty.

In the Citi Centre Building over the years, policy units move from floor to floor, never seeming to stay in one place. But Mental Health has stayed on level 8. It is still there. There was an Aboriginal smoking ceremony that occurred after Margaret's death, and it had to be on the lawns outside of the building, so as not to set off the fire alarms. Somewhat miraculously, just as the ceremony was underway, the wind blew and someone walking past triggered the automatic doors and the smoke went in. We remember what she stood for. We recognise both the simplicity and sophistication of her change management and most importantly - her values.

It would be another four years before a new plan would be in place.

Social Inclusion Board



Monsignor DavidCappo
Commissionerof Social Inclusion

After Margaret's death work continued on her policies, but there was a period without a plan. Then came the Social Inclusion Board reference. The Board was chaired by Monsignor David Cappo, Vicar General of the Roman Catholic Archdiocese of Adelaide

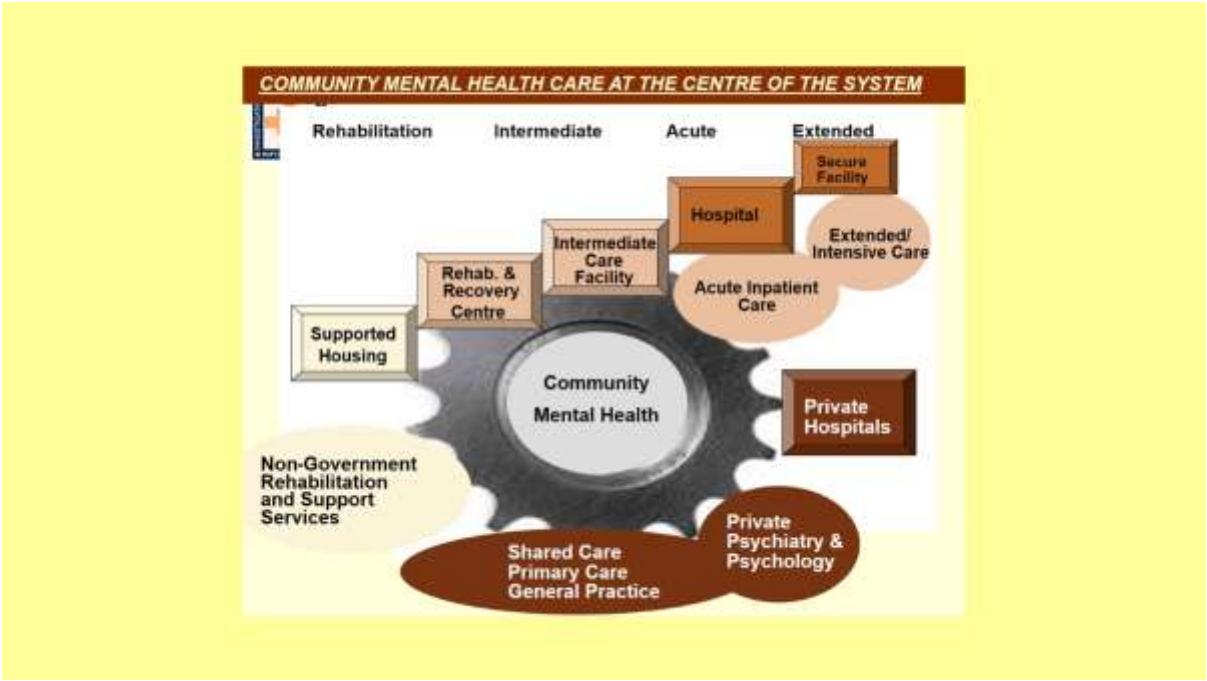
Public policy debate was being supercharged by Thinkers in Residence and the creation of a Social Inclusion Board with its broad experience including some wiley ex-departmental leaders who knew how to overcome resistance from the silos of SA Government departments. For the period of the Mental Health Reference, David Waterford was the young talented policy leader who led the unit that supported the Board.

It was clear at that time that mental health policy needed a whole-of-government approach, and in both the State and Commonwealth, mental health became a task for first ministers offices to tackle.

Before taking on the mental health reference, the Board had worked in homelessness. Guided by Rosanne Haggerty from New York, American homelessness policy had moved from what was known as a "housing ready approach" where homeless people had to demonstrate that they were ready for housing, to "housing first". Provide the house first and then other problems such as mental health or drug and alcohol use could be tacked second. This approach had been informed by mathematical observations - US research showing that the number of days a person has been homeless and using services is not "normally" distributed. Instead, it followed a power law distribution – there were a much smaller

number of people with long term homelessness who were using a large number of services. For these people, traditional shelters were supporting homelessness rather than solving it. Furthermore, not only was providing a house humane - it was also cheaper in the long run because of the added health costs accrued.

Some of this thinking informed the need to identify and support people who need high levels of support and might otherwise have many readmissions, as well as providing for early intervention to a much larger group.



This is the model of the Stepping Up report released by Cappo and the Social Inclusion Board. It was a stepped model based on increasing need. It introduced new steps in care, and the system was to be connected by mental health.

The work was associated with the rebuilding of Glenside as well as the creation of new centres. There were wins and there were losses.

The home-like residential centres were welcomed. The rehabilitation centres had long wait lists and seemed to over perform. However, by 2018 they could be hard to refer to, and had vacancies and more work was again needed. Three Intermediate Care Centres were built, but one was closed in 2015, and the future of another is still up for consideration today. Although such centres had a track record overseas as a hospital alternative, many medical professionals were skeptical, some skeptics became converted champions whereas others continued to harbour doubts.

The resource model was based on work from a WHO affiliated centre in Sydney, but there were doubts in the sector about the ability of the new stepped facilities to substitute for inpatient beds. Emergency Department waits increased, and more beds needed to be added. So, was this a problem with the modelling behind the plan, the policy, or the implementation? Would more staff achieve the outcomes seen elsewhere? These topics are still debated, but it is clear the new centres have supported people in a more preferred setting, and these people have had significant care needs that have been met. In recent years, Monsignor Cappo has worked in developing a mental health service '*Youbelong*' in Uganda.

Oakden

We will now fast forward to 2017 and Oakden.

For those who are unaware, Oakden was an aged care facility operated by the state's mental health services. On the left you can see the cover of the then Chief Psychiatrist report and the right is the ICAC report. In April 2017, the Chief Psychiatrist at the time released a report that was damning of the facility. There was not a model of care, in fact it was more like an institution from over 50 years ago. The infrastructure was inadequate, staffing models were inadequate, there was a failure of governance, a poor dominant culture and insufficient training. The ICAC report, released in February 2018, made recommendations about clinical governance, expectations, responsibilities, reporting, unannounced inspections, obligations, and the physical conditions of facilities.

Much work has followed – Northgate was quickly established with a new culture. New models were developed, and the Neurobehavioural Unit at the Repat was built and staffed as a new centre.

The role of inspections expanded with greater expectations of the use of the statutory functions of the Chief Psychiatrists Office.

We forget history at our peril. The resulting response should provide a sustainable impact if they are sustained, including the statutory regulatory response.

Consumer Input

The Consumer movement in mental health will need its own history – when it started, how it gained influence. It appears to have grown since the late 1960s and 1970s, been linked to other civil rights causes, and has had a link with the quality in health care movement, because consumer empowerment can lead to less health care errors and better outcomes. It became part of the accreditation of mental health services, and, in many respects, mental health can be seen to have led the rest of health care in this regard.

There are many consumer and carer representatives and leaders who can be acknowledged. I wish to mention two with whom I have worked.

Ann Smith has had local, regional, statewide, and national roles. Her achievements have been recognised in the Margaret Tobin Awards for excellence and with an Australian Honour.

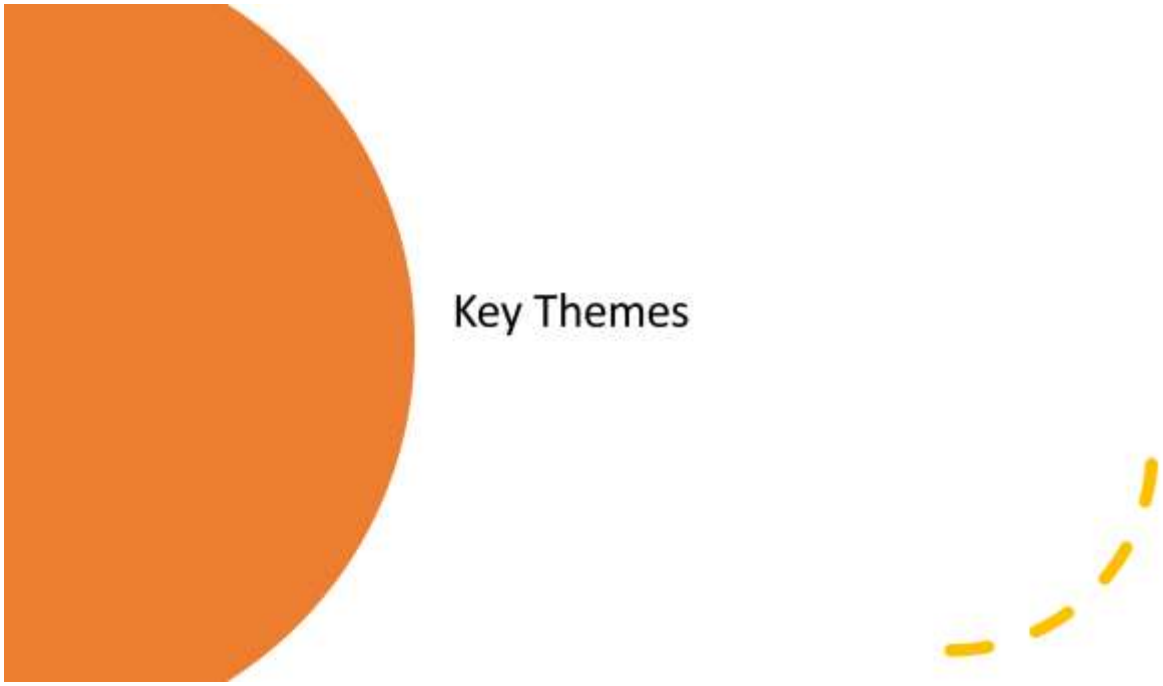
Her groups raised issues for individuals and service-wide. An example of advocacy that identified issues before their time, was a concern for the safety of patients on closed wards and their safety in their rooms. This

was raised in the late 1990s. She and her group proposed that persons should be able to lock themselves in their rooms so people could sleep comfortably at night and that another person could not enter. This is now a standard design feature and seems obvious in retrospect, but at the time was novel and was born from Ann and her group listening carefully to the concerns of fellow consumers.

Trevor Parry

Trevor Parry

Trevor is another consumer representative and advocate who had a strong local and statewide profile. He passed away some years ago from cancer, and after his death his memory has been honoured in the naming of the Trevor Parry Centre at Noarlunga - a residential community recovery centre. Trevor was involved in many projects and initiatives – in one he saw the benefit of Chronic Disease Self-Management which was being made available for people with physical ailments, and he wanted to see this made available for mental health, and so co-led a project.



In recent years the consumer movement in Australia and South Australia has taken up the mantle of human rights as a tangible vehicle for reform. Recent examples include the funding as a peak body of the Lived Experience Leadership and Advocacy Network, led by Ellie Hodges, the purpose of which is to amplify the voice, influence, and leadership of lived experience to drive change. They had a key role in developing the philosophy of care behind the states Urgent Mental Health Care Centre and has led key consultation on the future role of 72 new rehabilitation beds to be built in SA.

Aboriginal Mental Health

The impacts of invasion, colonisation, racism trauma and loss have adversely affected the mental health of Aboriginal people. Today we can see some light with new initiatives.

In Australia, historians have had some difficulty identifying Aboriginal people in asylums of the 19th century which can reflect the poor recording of Aboriginality.

In recent times there has been a familiar pattern. Aboriginal people are under-represented in voluntary mental health services but over-represented in involuntary care. People are reluctant to come forward early. This can be for several reasons, but a lack of confidence in the cultural safety of services is a common reason. Then when a person is so unwell that they might need involuntary care, the figures increase.

Dr John Cawte in 1960s reported that there were 95 Aboriginal people admitted to Parkside and Hillcrest, including children. He concluded then that Aboriginal people were more likely to be in long-term wards and were likely to be underutilising short term wards. He advocated that an outback mental health service be developed.

In 2006 the Stepping Up Report had made several recommendations related to how the system should be responding to the mental health needs of Aboriginal people. It recommended that: the Chief Executive take direct leadership authority in this area, that strategic audits were required, that a dedicated workforce plan be established for improving the training, recruitment and retention of Aboriginal people in clinical positions, that Aboriginal children be regarded as a priority population, and that a specialist mental health service be established at Glenside, supported by a dedicated research effort.

There was some progress in some areas but overall, much of the progress that occurred reflected the initiatives of local front line service providers rather than a statewide strategic approach.

The centre was never built, but at least now we do have the funding for an Aboriginal Mental Health and Wellbeing Centre that will provide care to individuals and families, and support the training of Aboriginal mental health professionals. This has been driven by Mr Ian James, Principal Aboriginal Mental Health Consultant in our Office, based on a WA model. With time, progress occurs. This centre will be governed by an Aboriginal Community Controlled organisation, and work in partnership with state services.

Prisons and mental health

Another theme from the past that recurs is the connection between prisons and mental health. We may now have hospitals, but people who experience mental illness are also over-represented in the prison population.

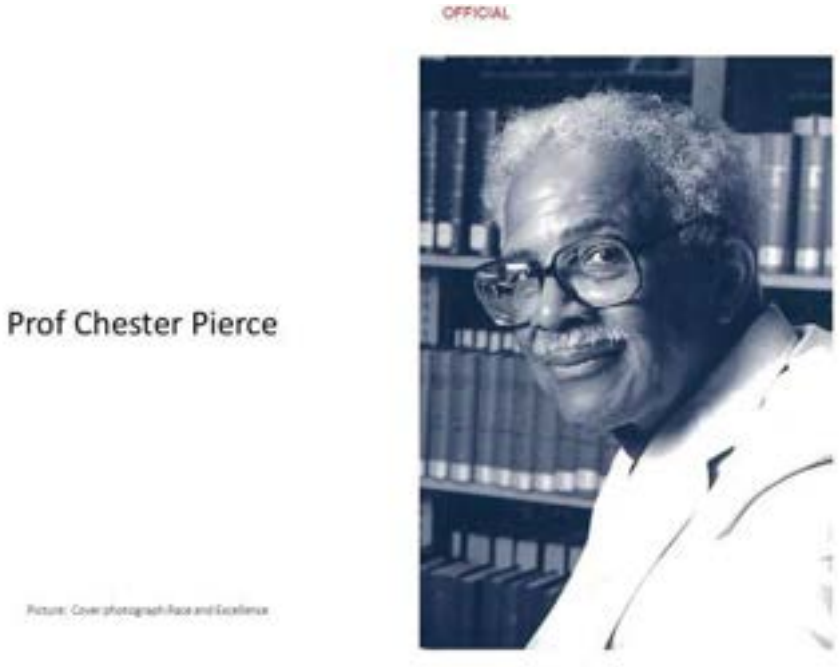
In 1939 a British psychiatrist and mathematician Lionel Penrose proposed what has become known as the Penrose hypothesis. This was based on his observation of an inverse relationship between the number of psychiatric hospital beds and the number of prison inmates in European countries. The theory that people who are released from hospital are vulnerable without support may then fall foul of the law.

This statistic has been studied over the years and in high income countries it does not seem to be replicated in the present day. But whether the mathematical equation holds out there is a clear link between a lack of

support and legal troubles. While this may be the case, the over-representation of people who have experienced mental illness in prisons is also recognised with even higher rates among women prisoners who have a high incidence of a history of trauma.

And then there are defendants who have been not guilty by reason of mental impairment or who are unfit to plead, known as forensic patients. We heard about James Nash, the Colonial Surgeon who moved patients from prison. It is somewhat fitting that the Centre in Adelaide that is established to admit both forensic patients and prisoners who need admission is named after him. However the main building of James Nash House constructed in 1987 is outdated and does not have capacity to admit all those requiring care, so forensic patients can still be housed in prison. This requires a special Direction made by the Health Minister or the Minister's delegate. When I was Public Advocate I advocated against this. As Chief Psychiatrist I now sign the Directions as the Minister's delegate. Those involved in this process seek to do this diligently, but nevertheless the same principals should apply – if patients have to be detained, they should be in a hospital not prison.

Tackling stigma



In the context of stigma, I wish to discuss some of the work of Harvard Professor Chester Pierce as it relates to racism that in more recent years has been applied to disability discrimination. His work does not specifically refer to South Australia, but he had a link to SA and his work is very relevant to the issue of stigma, and this is relevant to his work. I am also talking about Chet because I had the good fortune to know him

over 20 years and then link with the International Psychiatry Divisions at Massachusetts General Hospital established in his honour.

It is useful to firstly give a profile of Chet. He was known was an extraordinarily kind, humble and generous man - he also had a research interest in the psychology of extreme environments and had a link to Australia because of his travel to Antarctica.

In 1947 he was the first black college football player to play a game below the Mason Dixon line when his Harvard team met the all-white University of Virginia team. His Harvard teammates stood by him in response to segregation. To eat, the team walked through the hotel's kitchen door to get to the restaurant, because Chet was not allowed to go through the front door.

Chet had many research interests spanning his work on racism as well as clinical topics. He was a Commander in the US Navy, an adviser to the US Airforce Surgeon General, and in later years he worked with NASA on the Mars project. Notably, he was also an expert Consultant on the TV program Sesame Street – he wrote children's stories and had a keen appreciation of the impact of how blacks and whites were portrayed on television. The American Psychiatric Association's Human Rights Award is named in his honour.

Chet worked for government institutions and stood up for his core beliefs. I recall at one point during a period in the mid 1980's when I had regular contact with Chet, one week he could be travelling to Washington DC to give the air force advice on the selection of U2 spy pilots who would not crack under interrogation - and the next week he would be travelling to a court to give character evidence for a black activist. My recollection is that the activist was facing terrorism charges.

Chet Pierce coined the term "micro-aggressions" - subtle, seemingly innocuous degradations and putdowns. The person who administers the slight may be oblivious to what has happened. The comment or the action may seem harmless, though Pierce says the cumulative burden of a lifetime of these micro-aggressions flattens confidence and causes stress that diminishes health.

In recent years Pierce's term microaggression has been expanded in the literature to describe the unintentional, unpremeditated degradation of any marginalised group including people who have a disability or mental health issues. The link with mental health is two-way: a person may experience these put downs due to stereotypes about mental illness leading to worse morale and health. But for any marginalised group subjected to microaggressions, the perpetual trauma will in itself affect mental health.

There are many strategies that might address this such as addressing stereotypes about mental health problems, but in general, it can be argued that an ingrained human rights perspective based on equality and the recognition of personhood of all people should diminish these slights and put downs. For many years it has been recognised that stigma needs to be addressed by mental health professionals, and that self-stigma also needs consideration.

Pierce also saw race discrimination as a public health problem, to be solved across communities. Mental illness-related stigma, and ill-informed beliefs about disability, also create discrimination - either overt or covert. And the covert form, micro-aggression, can oppress people, deflating confidence and strength. Stigma is a public health problem.

Stigma is also a personal safety problem. People who are discriminated against may not speak up. People who are marginalised may not be listened to. Overcoming stigma improves connections and enhances safety.

The role of politicians

This presentation has not reflected on the roles of elected Government. Ministers are accountable for the system and have guided changes that at first may not be popular.

In reviewing Hansard I found the following quotation that refers to the lives of people with an intellectual disability, however the underlying rights are the same as for those for people with mental illness and aligns with today theme.

Parliamentary estimates, Wednesday 14 October 1981. The Minister of Health, who at that time was Jennifer Cashmore, said

"It is barely 20 years since the intellectually handicapped were lumped with the mentally ill and kept in a single institution. A great deal has been done in that 20 years, and the establishment of Strathmont bears evidence to that, as does the continuing work of Minda…

And then further in the same response the Minister says:

I can only say that the Government will be taking very much into account the views of parents and families, as well as the views of health, education, and social-worker professionals in adopting whatever course of action is proposed. We will be trying to proceed towards that ideal which is commonly described as normalisation - as the I.Y.D.P. poster says, 'What the hell is normal anyway?' I would prefer to describe it as the greatest possible degree of independent living for the intellectually handicapped person."

Autonomy, choice, and life are common rights, and these days we have the UNCRPD to guide us.

Where are we now?:

A key theme is the delivery of human rights – supporting equality in the community through respectful effective care and support.

Another theme is a reflection on leadership. Leadership from the community and sector in settings standards, but also the leadership of key government and political leaders who have had the courage to take South Australia to the next step and taken responsibility for those changes.

We are currently about to consult on changes to the South Australian Mental Health Act following the South Australian Law Reform Institute review. A key theme of that review was human rights.

The SA Government is also implementing the Suicide Prevention Act which underpins a strategy to involve departments across government in suicide prevention. Mental health is not just the prerogative of health departments. This Act was a first for Australia based on overseas models.

It is also helpful to reflect upon the key goals of the Mental Health Services Plan. These are not my goals, but what myself and the then Mental Health Commissioner heard from the community – Personalisation, which included better access to non-drug therapies and upholding human rights – including expecting human rights analysis on new initiatives; Integration – connecting services across government and the community, and Quality and Safety which includes suicide prevention and initiatives to reduce the use of restraint and seclusion.

Innovations come, and at first seem audacious, but then become business as usual. One example is the Urgent Mental Health Centre staffed by 50% peer workers and 50% clinical staff receiving people in distress. Another is the Towards Zero suicide approach based on models that show loss of life in services can be reduced by 20-30% by taking a range of simple measures. This is still a work in progress. It does illustrate Margaret Tobin's statement that it is not rocket science - it just needs to happen. Another development is the post Oakden standard, designed to Prevent and Eliminate Restraint where possible, based on best practice in Pennsylvania and the UK.

COVID brought new challenges. Mental health services to hotels, welfare calls to those in quarantine, and a range of specific services. Already existing gaps in child and adolescent services became more acute as the effects of the pandemic differentially affected young people. Right now, those services are expanding. Bed services for adults are also expanding, although not the asylum-type services of the past, but modern rehabilitation beds designed with consumers. To support all of this, a new human rights analysis tool has been developed to test human rights against mental health.

The development of mental health services has been an incredible journey - and what is offered continuously improves. Today I have talked about what can go wrong, but at least we know the problems, we have mechanisms to listen and to monitor our services. But we cannot assume that what has happened in the past cannot recur.

From Asylums to Community Care and Beyond – Human Rights and Mental Health: Lessons from History”

The changes in mental health systems over three centuries have been vast. Changes have been informed by both science and social movements, here and abroad.

Bio - Dr John Brayley MBBS, FRANZCP, Chief Psychiatrist, SA Health