Intention

In this session it is intended that students:

- understand the effect that labels and stigma have on people’s lives
- critically analyse the causes of stigma
- identify behaviours of their own and others, which are stigmatising
- tackle stigma (information to debunk myths; understanding and empathy; legislative protection).

Resources

- Activity sheet: Labels
- Activity sheet: Jam-jars, postcard and shoes
- Activity sheet: Fact, furphy, fear or fiction
- Information sheet: Mental illness: the facts
- Activity sheet: A thesaurus of madness

How to

ACTIVITY 1: Labels

OPTION A: If the shoe fits?

1. Give students a copy of Activity sheet: Labels and ask them to look at the different pairs of shoes. Write one word under each pair of shoes which describes one personal characteristic of someone who might wear these shoes.

2. In pairs students compare their words and talk about similarities and differences.

3. Collect responses from the whole class for one or two pairs of shoes.
4. Get students to identify words they would feel uneasy or embarrassed to have used in relation to themselves. Why is this?

5. Discuss the following sample questions with the class.

**Sample questions**
- Can you tell anything about people by their shoes?
- Do people judge others by the shoes they wear? Why?
- What other dress codes are people judged by?
- What types of labels might be used about odd behaviour?

OPTION B: Labelling jars not people

1. Refer students to the *Activity sheet: Jam-jars*.

2. Individually ask students to label each jam-jar using words that are sometimes given to people experiencing a mental illness, or whose behaviour is different or alternative in some way.

3. In groups of four, students are to select a few of the labels they have placed on the jars and discuss the following sample questions.

**Sample questions**
- What are some of the words people use to label odd behaviour?
- Which of these labels are used to restrict what we think are people’s capabilities? How does this occur?
- Which labels seem to stem from people feeling uneasy or embarrassed by different or odd behaviour?
**Teacher talk**

Odd behaviour in others might be thought of as:
- illogical, unusual, something we want to explain
- something which makes us uneasy, perhaps frightened
- something we see as unpredictable
- something we want to avoid.

Yet odd behaviour might be easily explained if we understood what caused the behaviour. Perhaps under the circumstances it is not so odd. Perhaps it is not so frightening. Perhaps we focus on the behaviour, not the person and problem underlying the behaviour.

Labels are powerful. Labels define who we are, and how we see others. Labels can be used to scapegoat. Labels can be used to restrict what we think people are capable of. Leave the labels on the jars and open our minds. People are more than their mental illness.

Stigma means a mark or sign of shame and disgrace or disapproval, of being shunned or rejected by others. It emerges when people feel uneasy or embarrassed to talk about behaviour they perceive as different.

**ACTIVITY 2: Fact, fear, furphy or fiction – a summary quiz**

OPTION: This could be set for homework or as an assessment task

1. Explain to students that the summary quiz has a range of statements about mental illness. Some may be myths, others are misconceptions, some may be true.

2. Each student will need the Activity sheet: Fact, fear, furphy or fiction and the Information sheet: Mental illness: the facts to help them respond to the statements.

3. Students circle the most appropriate response(s) to each statement and then explain on the sheet why they considered this / these to be the most appropriate word(s) to describe the statement.

4. Discuss responses to the Fact, fear, furphy or fiction exercises.
ACTIVITY 3: Creative writing

1. Students are to read *A Thesaurus of madness* and use some of the language from this to develop a short piece of creative writing describing an incident in the author’s life.

ACTIVITY 4: Newsletter

1. Have the class develop the *Activity sheet: Fact, fear, furphy or fiction* into a short article for the school newsletter. There could be a ‘MindMatters: Myths and Facts’ column which runs for a month or so to educate the whole school community.

A Mental Health Promotion strategy

Set up structures for reintegration of students or staff returning to school following a mental illness.
Jams - Jars

Labels Belong On Jars - Not People
The Issue Is Attitude
Fact, fear, furphy or fiction

Students should read /use Information sheets: Mental illness: the facts from session 1, in explaining their answers to the following statements. Tick one or more words that best represent your view about each statement. Then explain why you have chosen these words.

1 People are born with a mental illness.
   ○ fair  ○ unfair  ○ correct  ○ sometimes correct  ○ incorrect
   Why?

2 People with a mental illness are usually aware of their illness.
   ○ fair  ○ unfair  ○ correct  ○ sometimes correct  ○ incorrect
   Why?

3 Mental illness is something that comes and goes, but you never recover.
   ○ fair  ○ unfair  ○ correct  ○ sometimes correct  ○ incorrect
   Why?

4 People with a mental illness make poor parents.
   ○ fair  ○ unfair  ○ correct  ○ sometimes correct  ○ incorrect
   Why?

5 People with a mental illness have a flawed or weak character.
   ○ fair  ○ unfair  ○ correct  ○ sometimes correct  ○ incorrect
   Why?

6 People with a mental illness are usually dangerous.
   ○ fair  ○ unfair  ○ correct  ○ sometimes correct  ○ incorrect
   Why?
7 Most people with a mental illness live and work within the community.
○ fair ○ unfair ○ correct ○ sometimes correct ○ incorrect
Why?

8 People with a mental illness need to stay on medication.
○ fair ○ unfair ○ correct ○ sometimes correct ○ incorrect
Why?

9 People with schizophrenia are at greater risk of hurting themselves than people in the general community.
○ fair ○ unfair ○ correct ○ sometimes correct ○ incorrect
Why?

10 People with a mental illness are considerate work mates who are able to hold down a job.
○ fair ○ unfair ○ correct ○ sometimes correct ○ incorrect
Why?

11 Mental illness is reasonably common within the community.
○ fair ○ unfair ○ correct ○ sometimes correct ○ incorrect
Why?

12 Mental illnesses are a form of intellectual disability or some type of brain damage.
○ fair ○ unfair ○ correct ○ sometimes correct ○ incorrect
Why?

13 You can protect yourself from developing a mental illness.
○ fair ○ unfair ○ correct ○ sometimes correct ○ incorrect
Why?
Being the madwoman, I am also: a lunatic, a maddy, a mental case, a bedlamite, a screwball, a nut, a loon, a loony, a madcap, a mad dog, a psychopath, a maniac, an hysteric, a psychotic, a manic depressive, a megalomaniac, a pyromaniac, a kleptomaniac, a crack-pot, an eccentric, an oddity, an idiot, a basketcase, demented, moon-struck, hazy, unhinged, dippy, loopy, distracted, pixy-led, a scatterbrain, certifiable, crazy, loco, psycho, a nutter, possessed, fevered, bonkers, obsessed, bedevilled, troppo, starkers, schizo, potty, nuts, daft, dilly, a crackbrain, a fruit-cake, touched.

Being insane, I suffer from: mental illness, psychiatric illness, brain damage, unsoundness of mind, alienation, lunacy, madness, mental derangement, mental instability, abnormal psychology, loss of reason, intellectual unbalance, mental decay, a darkened mind, a troubled brain, a deranged intellect, nerves, imbecility, cretinism, morosis, feeblemindedness, queerness, having a screw loose, bats in the belfry, rats in the upper story, nervous breakdowns.

Being as I am, mad that is, I must be: not in my right mind, bereft of reason, deprived of my wits, as mad as a snake, a tinnie short of a slab, diseased in the mind, as mad as a hatter, wildered in my wits, not the full quid, a brick short of a load, off my rocker, round the bend, a candidate for Bedlam, foaming at the mouth, as mad as a meat axe, up the pole, a sandwich short of a picnic, out of my tree, off my face, off my block, over the edge, off my saucer, a shilling short of the pound, as silly as a wheel, off my trolley, as mad as a two-bob watch, a shingle short and I have a kangaroo loose in the top paddock.

Being wild and distraught, I live in a mad house, a mental home, a mental hospital, an asylum, an insane asylum, Bedlam, a booby hatch, a loony-bin, a nut house, a bug house, a psychiatric hospital, the rat house, the giggle factory, the rat factory, the funny farm.

I am many things, in many places.
Fool that I may be, mad that I may be.
I am, in all my precarious guises,
the creation of a cruel mind.

Extracts from ‘A thesaurus of madness (People must think I’m crazy)’ by Sandy Jeffs from Poems from the Madhouse published by Spinifex Press.
Intention

In this session it is intended that students:

• understand that people need support in dealing with stressful life situations
• differentiate between ‘normal’ responses to stress and difficulty, and those that may indicate the need for additional support from professionals
• consider who they could talk to if they were concerned about a friend or relative
• identify support personnel within the school relevant to mental health
• map the range of community-based health care services and groups available to support people experiencing mental illness and to support their families and friends
• note changes in the provision of mental health care services across the last 40 years.

Resources

• Information sheet: Something is not quite right
• Activity sheet: Scenario cards
• Resources to assist students to identify a range of community mental health resources when responding to the given scenarios, such as:
  • list of community mental health associations and services and support groups for particular illnesses
  • directory of community health and /or local government services
  • representatives of local community health agencies
  • internet access
• Information sheet: Care of the seriously mentally ill in Australia
ACTIVITY 1: Identifying the need for support

Teacher talk

When and how do we decide that a person is ill and needs assistance from health care workers? The love, friendship and support that usually come from family and peers to help young people through tough times may not always be enough.

1. Divide the class into eight groups. Two groups get set 1 of the scenario cards, two groups get set 2, two groups get set 3, and two groups get set 4. All receive the Activity sheet: Something is not quite right. Ask students to differentiate between ‘normal’ responses to stress and difficulty and those responses that may indicate that something is ‘not quite right’.

2. Students discuss their two scenarios. They use the check lists and the first three guide questions in each scenario to identify the issues of concern. They consider whether each situation is one where the help of family and friends would be sufficient, or one where assistance from health professionals should be sought.

ACTIVITY 2: Local services

1. Using local resource lists and directories, each group is to identify a range of services, agencies and groups that each of their characters could use to deal with the situation. The other guide questions after each character will assist students to develop a comprehensive response to this task.

2. For each character, the group produces a summary chart, indicating the issue (for example, eating disorder, depression or anger), and the range of agencies and services available.

3. Each group chooses one of their three characters to present to the rest of the class. They describe the situation, and identify how the character could go about seeking help and the range of supports this person could use.
ACTIVITY 3: Care of the seriously mentally ill in Australia

Working in small groups, students are to use the Information sheet: Care of the seriously mentally ill in Australia to identify changes in mental health care service over the last 40 years. They will consider how the type of institutional care provided for people with a mental illness may have affected community attitudes to mental illness. The following questions will help them to cover these issues.

1. Describe the sort of mental health services provided in Australia 40 years ago:
   - where people with a mental illness were located
   - what their living conditions were like
   - the availability and adequacy of treatment
   - the length of time people spent in institutional care and the factors which determined this.

2. Discuss how locking away people with a mental illness might have influenced community attitudes and beliefs about mental illness, for example:
   - they must be a danger to society if they are locked away
   - they are very different from other members of the community
   - they stay in those places all their lives – their illnesses don’t go away.

3. Find out how the move to community-based care came about, and where in the community people with a mental illness were likely to live once they left institutions.

4. Identify some of the difficulties associated with community-based care for people with a mental illness.

5. Find out about services provided in your area for people dealing with mental illness.

A Mental Health Promotion strategy

Provide accessible counselling service
Something is not quite right
Getting help early for mental illness

Something is ‘not quite right’ about the way someone close to you is behaving. You are worried. Is it serious or is the moodiness, irritability and withdrawn behaviour a stage to grow out of? Are drugs involved? Is medical assessment needed to help you decide if there is a serious problem?

Getting help early
The chances are that there is not a serious problem, and time and reassurance are all that are needed. However, if there is a developing mental illness, then getting help early is very important.

Being unwell for a shorter time means less time lost at school or work and more time for relationships, experiences and activities which help us stay emotionally healthy.

Check list 1

Behaviour which is considered NORMAL although difficult

Difficult behaviour at home, school or in the workplace

People may be:

- rude
- irritable
- over sensitive
- lazy
- rebellious
- weepy
- argumentative
- over emotional
- withdrawn
- shy
- thoughtless

These behaviours may also occur as a normal brief reaction to stressful events such as:

- breakup of a close relationship
- other family crisis
- exam failure
- moving house
- death of a loved one
- physical illness
- divorce
- other personal crisis

Probably no cause for serious concern

It is best if you try not to over react. Try to be as supportive as possible while waiting for the ‘bad patch’ to pass. If you are experiencing these problems it may be necessary to seek medical assessment.

If the behaviour is too disruptive or distressing for other people, or if the difficult behaviour persists, then you could seek counselling help or advice. Talk this over with your GP, school or workplace counsellor, Community Information and Referral Service, Community Health or Mental Health Centre.

Check list 2

What’s the difference between just having a bad day and something more serious?

Signs of clinical depression

- Feeling miserable for at least a week or two
- Feeling like crying a lot of the time
- Not wanting to do anything, go anywhere, see anyone
- Having trouble concentrating or getting things done
- Feeling like you’re operating in ‘slow-motion’
- Feeling tired and lacking energy – unable to get out of bed even after a full night’s sleep
- Having a change in appetite
- Feeling like there’s a ‘glass wall’ between you and the world
- Feeling hopeless or thinking of suicide
- Putting yourself down and thinking you’re no good

If you often experience a number of these things, you may be depressed. You don’t have to be alone with these feelings. Depression is treatable.
Check list 3

Behaviours which are considered ABNORMAL FOR THAT PERSON and may seriously affect other people.

People may:

- withdraw completely from family, friends and workmates
- be afraid to leave the house (particularly in daylight hours)
- sleep or eat poorly
- sleep by day and stay awake at night, often pacing around
- be extremely preoccupied with a particular theme, for example, death, politics or religion
- uncharacteristically neglect household or parental responsibilities, or personal appearance or hygiene
- deteriorate in performance at school or work, or leave jobs
- have difficulty concentrating, following conversations or remembering things
- talk about or write things that do not really make sense
- panic, be extremely anxious, or markedly depressed or suicidal
- lose variation in mood — be ‘flat’. Lack emotional expression, for example, humour, friendliness
- have marked changes in mood, for example, from quiet to excited or agitated
- hear voices that no-one else can hear
- believe, without reason, that others are plotting against, spying on, or following them and have extreme fear of, or anger at, those people
- believe that they are being harmed, or influenced to do things against their will, by, for instance, television, radio, spacemen, the devil.
- believe they have special powers, for example, that they are important religious leaders, politicians or scientists
- believe their thoughts are being interfered with or that they can influence the thoughts of others
- spend extravagant and unrealistic sums of money.

Seek a medical assessment as soon as possible

These behaviours are much stronger signs that someone needs to be checked out, particularly if they have been present for some weeks. There may only be a minor disturbance but a mental illness such as a psychotic disorder may be developing.

(Adapted from Something is not quite right: getting help early for mental illness, produced by SANE Australia 1998 and from YMAG, 1998)
### Peter, 14

Peter is 14-years-old and goes to the local high school. When he was 11 his mum died suddenly. Now his father is always at work and his older brothers and sisters run the household. Everyone is expected to pull their weight and be happy. However, even though everyone thinks he is happy, Peter says that sometimes he goes home, shuts the door to his bedroom and cries on his bed for hours. He does not really know why he gets so sad but often he feels very, very lonely.

1. What do you think is happening with Peter?
2. Is what’s going on here a problem for Peter? Why do you say that?
3. If you were a friend of Peter’s, who could you discuss your concerns with?
4. What could Peter himself do?
5. If you were in Peter’s situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn’t be able to be helpful?
6. Who do you think would be the person/place most likely to be able to help with Peter’s situation? Why? What might make it harder for Peter to approach that person? What might make it easier?
7. Is there anybody or any place that Peter would not approach for help? Why is that? Are there any ways of asking for help which might make things worse for Peter?

### Gina, 14

Gina is 14-years-old. She has breakfast at home but, when her mother is out of the room, puts most of it in the bin. When she gets to school she trades the lunches her mother gives her for a piece of fruit. If she goes out with friends she might get a plate of food, but most often gives most of it away to other people. On sports days, she never gets changed in front of anyone else. At school some of the other kids have started to make jokes about how bony she is.

1. What do you think is happening with Gina?
2. Is what’s going on here a problem for Gina? Why do you say that?
3. If you were a friend of Gina’s, who could you discuss your concerns with?
4. What could Gina herself do?
5. If you were in Gina’s situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn’t be able to be helpful?
6. Who do you think would be the person/place most likely to be able to help with Gina’s situation? Why? What might make it harder for Gina to approach that person? What might make it easier?
7. Is there anybody or any place that Gina would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Gina?
**NICK, 15**

Nick is 15-years-old. He comes from a large family of older brothers who are all now at university. He has never done as well at school as his brothers did and over the last year, his father has been making him bring in his homework after he’s finished it and sometimes there are big fights afterwards. Lately, when he goes to do his homework he feels sick, gets headaches and sometimes feels really dizzy. Last week on the way home he had to get off the bus because he got so nervous at the thought of going home that he couldn’t breathe and thought he was going to throw up.

1. **What do you think is happening with Nick?**
2. **Is what’s going on here a problem for Nick? Why do you say that?**
3. **If you were a friend of Nick’s, who could you discuss your concerns with?**
4. **What could Nick himself do?**
5. **If you were in Nick’s situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn’t be able to be helpful?**
6. **Who do you think would be the person/place most likely to be able to help with Nick’s situation? Why? What might make it harder for Nick to approach that person? What might make it easier?**
7. **Is there anybody or any place that Nick would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Nick?**

**ALI, 22**

Ali is 22-years-old and works with the biggest steel company in town. He started going out with a girlfriend and thought things were going really well. He asked her to marry him. However, she said she wasn’t ready for a commitment and instead she went overseas — on her own.

Since then, he can’t stop thinking about her and how hurt he feels. He hasn’t been able to sleep. He’s been at the pub every night. He’s been feeling like a ‘pent up volcano’. The blokes at work have started to hassle him a bit about ‘not being on the job’, and last week, when the foreman yelled at him about something, he started screaming back and almost threw a punch. He’s been told to take some time off.

1. **What do you think is happening with Ali?**
2. **Is what’s going on here a problem for Ali? Why do you say that?**
3. **If you were a friend of Ali’s, who could you discuss your concerns with?**
4. **What could Ali himself do?**
5. **If you were in Ali’s situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn’t be able to be helpful?**
6. **Who do you think would be the person/place most likely to be able to help with Ali’s situation? Why? What might make it harder for Ali to approach that person? What might make it easier?**
7. **Is there anybody or any place that Ali would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Ali?**
<table>
<thead>
<tr>
<th>TONY, 13</th>
<th>KATE, 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tony is 13-years-old and in his second year of high school. He has a disabled younger brother who is always really sick and takes up most of his parents’ attention. He’s normally pretty quiet at school and has always done well. He hasn’t wanted to make trouble for his parents because there’s already enough stress at home. However, a few months ago, he took the day off school and while he was hanging around the shops, stole a baseball cap. Everyone said what a great cap it was when he wore it to school the next day. Since then, he’s been stealing from stores in the area on a regular basis. Often he gives presents to his brother, his friends or to his mum.</td>
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<tr>
<td>Kate is 19-years-old, has left home and is looking for a job. Lately, she is finding it really hard to get to sleep at night and then get out of bed the next morning. She has not had a job interview for a long time and has difficulty paying her bills. Her friends have noticed that she doesn’t want to come out with them any more. She has been using sleeping pills to help get to sleep at night and has been talking a lot about how hopeless things are and that things are never going to change for her.</td>
<td></td>
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<tr>
<td>1 What do you think is happening with Tony?</td>
<td></td>
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<tr>
<td>2 Is what’s going on here a problem for Tony? Why do you say that?</td>
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<td>3 If you were a friend of Tony’s, who could you discuss your concerns with?</td>
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<td>4 What could Tony himself do?</td>
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<tr>
<td>6 Who do you think would be the person/place most likely to be able to help with Tony’s situation? Why? What might make it harder for Tony to approach that person? What might make it easier?</td>
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<tr>
<td>7 Is there anybody or any place that Tony would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Tony?</td>
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<tr>
<td>1 What do you think is happening with Kate?</td>
<td></td>
</tr>
<tr>
<td>2 Is what’s going on here a problem for Kate? Why do you say that?</td>
<td></td>
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<tr>
<td>3 If you were a friend of Kate’s, who could you discuss your concerns with?</td>
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<tr>
<td>4 What could Kate herself do?</td>
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<tr>
<td>5 If you were in Kate’s situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn’t be able to be helpful?</td>
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<td>6 Who do you think would be the person/place most likely to be able to help with Kate’s situation? Why? What might make it harder for Kate to approach that person? What might make it easier?</td>
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<td>7 Is there anybody or any place that Kate would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Kate?</td>
<td></td>
</tr>
</tbody>
</table>
**SONYA, 22**

Sonya is 22-years-old. She works at a local coffee shop and says the boss looks over her shoulder all the time and hassles her. She is particularly worried about one incident that happened about six weeks ago. During the busy lunch period, Sonya was hurrying with a tray of plates and glasses. She tripped and dropped the tray, breaking everything on it. The boss started screaming at Sonya in front of all the customers and staff. Since then, Sonya has told this story to her friends over and over. She also says she feels sick in the stomach almost all the time and keeps going over the incident in her head. She can’t eat or sleep properly.

1. What do you think is happening with Sonya?
2. Is what’s going on here a problem for Sonya? Why do you say that?
3. If you were a friend of Sonya’s, who could you discuss your concerns with?
4. What could Sonya herself do?
5. If you were in Sonya’s situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn’t be able to be helpful?
6. Who do you think would be the person/place most likely to be able to help with Sonya’s situation? Why? What might make it harder for Sonya to approach that person? What might make it easier?
7. Is there anybody or any place that Sonya would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Sonya?

**NIGEL, 20**

Nigel is 20-years-old. He’s in his second year at university and has found being there a real struggle. He’s had trouble sleeping and feels very negative about people and life in general. A few weeks ago he began having some strange experiences. For example, he began seeing people out of the corner of his eye who were looking straight at him but who were not there when he looked again. He was also sure there was someone yelling at him and calling his name loudly in his ear. It seemed like every radio announcer was talking directly to him on the radio and telling him what to think or what to do.

1. What do you think is happening with Nigel?
2. Is what’s going on here a problem for Nigel? Why do you say that?
3. If you were a friend of Nigel’s, who could you discuss your concerns with?
4. What could Nigel himself do?
5. If you were in Nigel’s situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn’t be able to be helpful?
6. Who do you think would be the person/place most likely to be able to help with Nigel’s situation? Why? What might make it harder for Nigel to approach that person? What might make it easier?
7. Is there anybody or any place that Nigel would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Nigel?
Schizophrenia Australia Foundation has completed a wide-ranging survey and rating of state and regional services (Care of the Seriously Mentally Ill in Australia, 1994).

The main objectives of the survey were:
- to put information on public record
- to identify good services to learn from
- providing information which can be used to carry out improvements in existing services.

The following excerpt from the survey provides an historical background to mental health services in Australia over the last 40 years.

Historical context: the last 40 years

Dr Eric Cunningham Dax

In 1952, Dr Eric Cunningham Dax arrived from England to take up a position as chairman of the newly-founded Mental Hygiene Authority of Victoria. A decade later, he recalled those times in his book, Asylum to Community.

Mental health services in Australia owe a tremendous debt to Dr Dax: his energy, ability, dedication and vision led them out of their darkest period into the modern age.

‘The [Mental Health] Department by 1952 was mostly in a state of utter neglect and far below the standard of the oldest and most backward hospitals at that time in Great Britain or those seen in Europe... The wards were mostly very dirty and little more could be expected from the unsanitary state of affairs. Chamber pots were used nearly everywhere and frequently stored during the day in the same place as the food was prepared. The smell was abominable because straw mattresses were fairly generally used and only periodically refilled, the filthy straw being turned on to a heap. The toilets were without seats and frequently broken and were quite insufficient in numbers, while the totally inadequate washing accommodation was also dreadful. There was a considerable amount of mechanical restraint and solitary seclusion used, and the staff must have been in the greatest possible difficulties to know what to do for the patients, with no facilities available in most cases for their care. These deplorable conditions were accentuated by an overcrowding in the nature of 1,500 people, many of whom were sleeping on mattresses on the floor. The serving of the food and its presentation was revolting.’

On taking up his position, Dr Dax set about raising the standard of mental health services. Three years later, Stoller and Arscott could write, ‘Victoria was, in our view, the best-equipped state in the Commonwealth, both in regard to mental health facilities and to planning.’

Mental health services in Australia owe a tremendous debt to Dr. Dax: his energy, ability, dedication and vision led them out of their darkest period into the modern age.

The Stoller and Arscott Report, 1955

The Commonwealth Government commissioned a psychiatrist, Dr Alan Stoller, and an administrative officer, Mr K. Arscott, to survey mental institutions in Australia.

Most of the institutions at that time were mental hospitals: there were few general hospital psychiatric units, and few outpatient clinics. Hospitals everywhere were overcrowded: this phrase comes up constantly.

Western Australia was ‘backward psychiatrically’. South Australia was relatively ‘backward’. Queensland hospitals were ‘not good’ and needed to be decentralised. In New South Wales, ‘the Mental Hygiene Department has lagged behind world developments in psychiatry. It has been so starved of essential monies, even for adequate maintenance, over so many years...’ Callan Park Hospital in Sydney had 1,845 patients in residence, with ‘floor beds solidly packed to such a degree that any
patient wanting to get to the lavatory at night, had to crawl over patients. Hygiene facilities, especially in dormitories, were appalling.’

‘Tasmania’s mental hospital also had certain parts which ‘could only be described as appalling’ and maintenance was ‘shocking’.

Victoria’s mental hospitals were improving, though the words ‘appalling’, ‘shocking’ and ‘dreadful’ were still used to describe the Kew Mental Hospital.

Around the country, staffing levels were ridiculously inadequate.

Goodna Mental Hospital, near Brisbane, had 2 403 patients, making it the largest hospital in Australia: there were seven medical staff, none with full psychiatric qualifications. The hospital had no social workers or occupational therapists.

Bloomfield Mental Hospital in Orange, NSW, had two psychiatrists and one medical officer for 1 655 patients. The Reception Houses had somewhat better staffing but they had a very high rate of turnover, for example, Darlinghurst Reception House in Sydney had 3 000 acute psychiatric admissions a year.

Reading their report today, one can feel the despair that politicians, bureaucrats, mental health professionals, relatives, and most of all, patients, must have felt at this overwhelmingly dreadful situation.

1955 to the mid 1960s

After the Stoller and Arscott Report, the other states slowly set about following Victoria’s lead. The Commonwealth Government gave ten million pounds to the states to improve their mental hospitals.

More staff were recruited, staff training was upgraded, rehabilitation programs were introduced, buildings were renovated and new ones built: out-patient clinics were opened in locations away from the hospitals.

The problem of the awful overcrowding was tackled too, and the numbers in hospitals levelled off and then began to fall gradually.

There were two ways the overcrowding was solved. One method was to discharge long-stay patients from the back wards of the hospitals.

This was relatively easy in that period: many patients gradually lose their symptoms over time, and in the hopelessly staffed mental hospitals prior to the late 1950s, there was no-one to assess them with a view to discharge. This could now begin to happen.

The psychiatrists say they began deinstitutionalisation not to save money, but because they believed it was better for the patients.

What is more, medication was available to control symptoms. Patients were assessed, placed into hostels or boarding houses, and followed up by domiciliary staff from the hospital. As they left the hospital, beds in the ward were reduced.

The other method of alleviating overcrowding was ‘non-institutionalisation’. Patients admitted to hospital had their symptoms rapidly brought under control with the new medication.

When they improved, they were discharged back home and given out-patient appointments. It was difficult to get from the admission ward to the long-stay wards because beds were being dismantled.

By the late 1960s, the despair of the past had gone. The walls had come down from around the mental hospitals, the medication seemed to help many individuals to improve: stigma was decreasing: overcrowding was disappearing: staff were plentiful.

What had brought about the change?

The commonest answer is that administrators did it to save money. But talking to psychiatrists who were working in the hospitals at the time, there is no support for that allegation.

The appalling nature of the hospitals conflicted with the increased social consciousness and responsibility that had developed during and after the Second World War.

Something had to be done. None of the psychiatrists claimed there was any pressure on them from administrators to discharge patients.

One psychiatrist who was superintendent of a mental hospital recalls a senior administrator expressing concern that caring for people outside hospital was going to cost more.
The psychiatrists say they began de-institutionalisation not to save money, but because they believed it was better for the patients.

Following the 1961 Royal Commission into allegations of cruelty and neglect in Callan Park Mental Hospital, the principles of decentralisation and community orientation were stressed.

Dr Bill Barclay became Director of State Psychiatric Services, and the period when he held that office, and subsequently became one of the five health commissioners for New South Wales, was a time of most rapid decline in that state’s mental hospital population – from 12,421 in 1965 to 7,426 in 1975.

When the intellectually retarded are excluded from the statistics, the numbers fall even more sharply – 8,889 in 1965 to 4,382 in 1975, a reduction of 50 per cent. The ratio of inpatients to staff fell from about three to 0.94 over this time.

The total money spent on operating the mental hospitals increased 63 per cent from $53.6 million to $87.3 million, but when allowance was made for inflation, the average weekly cost per patient increased 172 per cent, from $83 to $226. Total admissions went from 15,689 in 1965 to 23,628 in 1975, an increase of 50 per cent. Shiraev has broken the admission figures down by diagnosis.

Admissions with a diagnosis of schizophrenia increased by 41 per cent: a diagnosis of depression (psychotic and neurotic) increased by 62 per cent: and a diagnosis of alcohol-related disorders increased by 113 per cent.

This last group, from 1973 onwards, exceeded the number of admissions of people with schizophrenia. A new clientele had entered the mental hospitals.

Mid-1960s to mid-1970s
The late 1960s and early 1970s were heady years for mental health staff, and several psychiatrists have written about them as the golden years of public psychiatry.

Certainly they were golden compared to the immediate past. Probably the most important ingredient was the feeling of hope that things were improving and would keep on improving.

Patients were being placed in the community without any worry that the boarding houses were often of poor standard or overcrowded: that could be fixed.

In the meantime, the domiciliary nurses from the hospitals called regularly to see that the patients took their medication. Most individuals with mental illness could get jobs: even if they could not keep them, it did not matter because another one was waiting in the full employment market of the time.

Housing was not a major problem: and most patients from the admission wards were going back to their families.

There were senior psychiatric staff in the mental hospitals (private psychiatry was not reimbursed by health insurance, and Medicare had not yet commenced). The idea of the so-called ‘schizophrenogenic mother’ would soon disappear.

Prior to 1973, the development of community mental health services was rudimentary and consisted of a few staff, mostly nurses, going out each day from a mental hospital base to a community outpost to provide services for discharged patients.

Following the elections of the Whitlam Government, the Commonwealth poured in money to the states to establish community mental health services: so much money in such a short time that the states had difficulty digesting it and supervising the expansion.

Amidst all the euphoria, staff in the new services began to ‘do their own thing’.

The task of helping the mentally ill was much more difficult, much more complex than anyone had realised in the 1960s

This usually did not involve spending much time with the mentally ill. The new priorities involved treatment of those with neurotic disorders, or with no diagnosable mental disorder but with marital or family problems.

Community development became popular, and ‘prevention’ – that ill defined concept – was everybody’s goal. Community mental ‘health’ was going to fix everything.

1975 to the Present
It took only a few years for the euphoria to wear off. Problems which had been smouldering for years now became apparent, and increased, after 1975, with the worsening economic situation.

The dismiss of the families caring for their mentally ill relatives began to emerge (and, in fact, led to the formation of the Association for the Relatives and Friends of the
Mentally Ill, in NSW in 1976, and the first Schizophrenia Fellowship, in Victoria in 1978). Complaints by families about being blamed for causing mental illness were voiced.

The plight of the mentally ill in the boarding houses and special accommodation houses surfaced: although the residents told researchers they preferred the boarding houses to the hospitals, the houses were seen as a form of ‘trans-institutionalisation’, and calls were made for something to be done.

As the economy worsened, the mentally ill now had greater difficulty obtaining jobs, let alone keeping them.

The Commonwealth Government changed its method of funding for the state governments’ health services: moreover, they cut the funding at the same time as the state governments were experiencing financial problems.

As a result, mental health services began to be cut back. The links between community mental health centres and the mental hospitals were severed, and continuity of care became tenuous.

Psychiatrists were leaving the public sector because Medicare guaranteed them a high income and they were free to practice as they wished.

The 1970s ended, and so had the hopes of a decade earlier. The task of helping the mentally ill was much more difficult, much more complex than anyone had realised in the 1960s.

The early 1980s added another problem as the mentally ill turned up among the homeless populations in the inner cities. This phenomenon has been popularly attributed to deinstitutionalisation: the term ‘back wards to back streets’ came into vogue to describe the process.

The evidence shows something different in Sydney. Teesson and Buhrich found 22 men with a diagnosis of schizophrenia in a random sample of 86 men in a large shelter for homeless men. Although some of the men had been going in and out of psychiatric hospitals and clinics for many years, only two had gone to the shelters prior to 1981: most had gone into the shelters for the first time in the period 1981–84.

The peak period of deinstitutionalisation in New South Wales was 1965–1975. Clearly other factors must be involved.

One obvious one was the tightening of the Sydney housing market around 1980. There must surely be others. The whole topic awaits its researcher. (In the United States there was a similar long-time lag between the decrease in the population of the mental hospitals, which began even earlier, and the appearance of the mentally ill among the homeless in the late 1970s.)

The 1980s and 1990s saw the struggle to readjust taking place in a continually worsening economic climate.

The mentally ill had left the mental hospitals, but the money allocated for their care was still back in the hospitals. Attempts by bureaucracies to unlock the money had little success, and in places have resulted in bitter fights with unions.

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