7

The Penny Dropped: The Psychiatrist

I was in the paediatric training program at the Royal Children's Hospital and in that job there were two things I remember that influenced my decision not to continue with paediatrics and to choose psychiatry instead. I was in the oncology unit for quite a while, treating sick and often dying children. I found that it was something I perhaps wouldn't want to do for the remainder of my professional career if I was a paediatrician. The second thing was that part of the unit in which I was working admitted children who had been subjected to suspected child abuse and neglect—that involved treating those patients in conjunction with a child psychiatrist. I became interested in the psychological and social factors that brought those children into hospital and the mental health as well as physical impact of the abuse and neglect.

In 1979, when I was 25, after I left the children's hospital, I did a relieving term in adult psychiatry in Lowson House, then the in-patient psychiatric unit in the Royal Brisbane Hospital. Walking into that ward was very different. It was different culturally and with different standards than the children's hospital. Lowson House wasn't as well funded. It was very busy. It was common, in those days, to put out stretchers when they'd reached the bed limit in the four wards. You'd have to walk between old folding stretcher beds in the middle of the ward. When those filled up it was common for the registrar who was on call to go to the open wards and discharge patients in the middle of the night to make beds available for

new admissions. I'd come on the next morning and find that some of my patients had been discharged during the night, without telling me, to make way for others coming in.

There were locked wards so I had to carry big lumps of keys on my belt. It was crowded. It was a very different place both physically and socially compared with other wards where I'd worked. There were some older teenagers in Lowson House. I felt it was a place where I could do some good. I was busy—there was lots to do and lots of patients. I felt that these people were really suffering. The view, in some parts of medicine, was then and still is that the suffering from mental illness is not the same as that from other illnesses—that people with mental illnesses aren't as deserving as those with other illnesses. I never felt that. I saw the terror in people's eyes when they were hallucinating or the crushing impact of a severe depressive illness. I felt it was a place where we needed good doctors and nurses. I ended up staying in psychiatry.

I had first been to Wolston Park Hospital as a medical student during my psychiatry term. I went back again during my five-year training to become a specialist psychiatrist, which included a minimum rotation of six months in a psychiatric hospital, which I did at Wolston Park. Then I came back to Wolston Park later in my career as a consulting psychiatrist. In my six months there as a psychiatry registrar I had patients in several wards—in the open ward of Lewis House and in the closed male and female wards: Pearce House and Osler House. I also treated teenage patients. The practices were very restrictive. There was very little patient autonomy or attention to patients' rights. It was very institutional, very controlling. It was basically about containment rather than a patient's recovery. Some of the teenage patients were unhappy and would complain about being in the hospital and for others it had become an alternative home for them, which said a lot about the terrible circumstances that they were in before they got admitted to Wolston Park.

Some of the problems those teenagers were having in the community would manifest in behaviour—acting out—which included self-harm and violence. When those things repeatedly occur, it's not very long before someone slaps a mental health label on the person, which then gets them into the mental health system. That system, for better or for worse, is perceived as the place where that sort of behaviour is better contained because there are locked facilities and mental health legislation that can detain people against their will, but self-harm and aggression don't always

correlate with the person having a mental illness. There are many other reasons why people do those things. So I think the mental health system was used to provide behavioural control and that still happens. There is pressure from other parts of the health and welfare system to say, 'Look, we can't handle this person. They're too aggressive or they're threatening self-harm. You've got to take them.'

That's been a tension ever since I have worked in the mental health system. When I see a patient I try to work out what has caused the presentation. The behaviour could be due to psycho-social issues in their home, their family, from substance abuse or a range of things. The treatment would be to try to change those environmental factors rather than treat the symptoms caused by those factors. The problem is that the health system doesn't have control over those environmental factors so if the problem is that the person is being victimised in the family with whom they're living—being abused—or whether they're part of a group of individuals who have antisocial behaviour or substance abuse, mental health treatment of the person does not change that. If you discharge them and they go straight back into that environment, then you're putting them back into the situation where the problems arose. But if you admit them to hospital, in the mental health setting, then you're putting them in a situation where they've got a psychiatric label, they're given medications, drugs, and that isn't going to fix the cause of their problems. So you're in a no-win situation.

When I think about the young patients I had when I was a young doctor, there are two that stand out. There was one teenage patient who I treated and one night I was on call and I walked into the ward and I saw the male nurse holding the patient down, trying to force medicine into her throat. The nurse stopped when he saw me but I reported that incident and that nurse was actually charged. I remember going to court to give evidence over what I saw and I remember that staff member not being convicted but being dismissed for a range of other reasons. Over 30 years later, I got an email from that teenage patient, thanking me for trying to help her. Maybe the fact that someone would stand up for her was something that helped her. When I got that email, I was stunned. I kept the email because you don't often get those sort of things. I often don't hear about the good outcomes. The patients that come back are those who are not making it. If I had to guess, at the time I would have thought she wouldn't have made it, but she did. To be honest, I didn't report him just for her. I did it because I was so angry at the male nurse. I just wanted to stick it

to him and that's probably not a good reason. Sure I was sticking up for my patient too, but I just couldn't believe that nurses could do those sorts of things.

What I witnessed was probably just the tip of the iceberg. Much worse things than that went on but they didn't happen when the doctors were around. I just happened to be on call and walked onto the ward and just saw what happened by chance. The medicine was something innocuous, which was one reason the nurse got off, I understand. The process, in the hospital, was to report it for internal investigation. So I reported it to the medical superintendent who I guess reported it to the director of nursing who then initiated an investigation, which I understand, led to that nurse being suspended. The reason that the nurse was dismissed was because they had lots of other concerns about him, as I understand it. My concern was just one and it wasn't proven in court but I was happy to go to court and give evidence even though he was not convicted of that particular assault.

That was the only incident I saw and reported. I heard about a few others but I wasn't directly involved in them. As a registrar I wasn't particularly high up in the pecking order. Working there made me think about whether that's the sort of psychiatry I wanted to do and I decided that I would look after the patients that I had responsibility for, while I was there, as best as I could then to get out of there and move on with my career. I felt it was someone else's job to fix the endemic problems. The hospital was being reformed while I was there in the sense that some of the locked wards were being opened. The number of patients per ward was being decreased so it wasn't as crowded. Beds were being closed. Wolston Park was the largest hospital that existed in Australia. It had something like 2,500 beds at one stage. When I was there it had about 1,000 beds and was decreasing. I thought that maybe when they sort all that out, it will get better.

There was another case I remember. There were two very young girls, aged between 10 and 12. I saw them when I was in the children's hospital doing paediatrics. They were admitted to the child abuse unit. They were malnourished. They were thin. They had eczema. They were really distressed young kids. They had a single mother who I remember was a very obese woman who had multiple partners. She wasn't really looking after these kids. She didn't physically abuse them as far as I knew but they were certainly neglected. We called in the child protection team and they came over and there was this big meeting. I was just a junior doctor but

I remember being very offended and being indignant about how terrible this situation was and how we had to get these poor kids away from this hopeless mother. Anyway, the kids were taken off the mother and they were put into foster care. I saw the elder of the two girls years later in when I was a psychiatry registrar, when she was maybe about 16.

I remember her coming up to me and saying, 'You don't remember me, do you?' I looked at her and I didn't remember her and she said, 'You did a terrible thing to me. I saw you at the children's hospital and you took me off my mother.' The penny dropped. She said something like, 'No matter how bad it was with my mother, I was never sexually abused. But when they put me into foster care, I was! I blame what happened at the children's hospital for that.'

I felt my guts fall to the floor. I remember thinking how naive I was and how I was part of the decision to take that 'poor' child away from that 'terrible' mother. I was very judgemental without any thought to where that child was going. Was there a better option for that kid? Should we have left her with the mother and poured the resources that were used in the foster care system into the family to try to help there, rather than to think that the simple solution was to put her into care? That stayed with me. I guess it's all a learning experience but that was obviously a wrong call I was part of back then.

So it goes back to the environment and the problems mental health professionals have when they feel powerless to influence the cause of the problems. Seeing a child and getting them out of a bad situation is perhaps not always the right answer, especially taking a child away from their mother. Obviously we think differently about it now but back in late 1970s and early 1980s I was clearly on a steep learning curve.

I grew up in a middle-class part of Brisbane. I went straight out of high school into medical school, straight out of medical school into the Royal Brisbane Hospital. So my perspective of what was acceptable, what was normal and what wasn't was all shaped by my life and experience. I never went to a private school or anything like that but I did go to a middle-class school in the eastern suburbs of Brisbane and so my take on what I saw was from that perspective. Any kid who didn't get fed in the morning or was too thin or hadn't had their eczema treated by a doctor, well that was wrong and that parent was failing and something needed to be done. I was judging them through my lens. That's what happens. Most health

professionals are middle class or upper middle class. They judge what they see coming through the door and in the public health system the patients and their families are often from a much less advantaged environment.

The other thing that attracted me to psychiatry was one of those moments when you realise that you totally missed something important about a patient. It was not something I missed about the physical diagnosis; it was missing something psychological. I went into the children's ward where I was working in the morning and there was a baby that had been admitted overnight. The kid was aged about one or two. I remember saying to the very experienced charge nurse, 'Any new admissions, sister?' She said, 'Yes, doctor.' She gave me the cot number and I went down to the child abuse section and this kid was standing on the edge of the cot. I walked up and the kid put his hands up to be picked up. So I picked him up and he hugged me and I turned to the sister and said, 'Oh, isn't he a lovely kid?' She said, 'That child is disturbed.' I looked at the sister and I looked at the kid who was hanging onto me and I was thinking, 'What's wrong? He's a lovely little kid.' She said, 'That child doesn't know you, has never met you before and is hugging you like you're his father.'

The sister was a woman who had worked in children's health for 30 years. The penny dropped again about how naive I was and how an 18-month-old shouldn't actually be reaching out to any stranger who walks past. I had a lot to learn about judging a kid who has been through trauma. So my initial reaction, whether it was to get a poor kid away from a terrible mother, or thinking a kid was lovely because he wanted to hug me, was all about me and my reaction and not about what's wrong with the patient. So those things stayed with me. They made me think that this is much more complicated, but also more interesting, because it's about biological, psychological and social factors, melding them together, understanding what's really going on and why, and how I can help.

It was and still is important to develop a sense of humility about what I can and can't do and not to over-medicalise everything. Not all problems can be solved by medical solutions. One of the things that attracted me to psychiatry was exactly that.

I remember being a first-year resident in the Royal Brisbane in orthopaedics and they'd talk about 'the fractured femur in bed 11' or 'the dislocation of the head of the radius in bed 13'. Even back then I hated that. I'd think, 'Hang on! Come on! There is a person in that bed'. That way of referring

to a patient really ground on me. I'd talk to the patient and knew that I had to treat more than just the injury: what about the rest of that person? In psychiatry, I think about more than the diagnosis, especially if I want to be effective. The fact that I can't influence other factors causing the problem is frustrating but I can at least identify them and help the person pursue a non-medical solution or bring in non-medical resources to help. But if you don't see them you can't start to do that.

Ultimately what I learned in my career is that if I can change the system, I could help more patients indirectly than I could ever help seeing them one at a time in clinical practice. If I could make the mental health system better, I would still help patients even if I wasn't their treating doctor.

Regarding those who were institutionalised as children, I'm not a fan of seeing them continuing to be victims. That's disempowering for them. It can be an attributional problem—their problems coping as adults can be all because of 'How I was treated when I was in that institution'. For most, it was bad before they went into the institution. It was bad in there and bad after they got out. The institution was often one bad experience among many. For me it's about saying, 'Despite all of that, you can overcome it, but those who worked in that system need to acknowledge that what we did then made it worse, not better. We didn't help you then as we said we were going to.'

Some were abused. It was heaping more abuse on existing abuse. For others the system was more benign. For a minority in those type of institutions it was actually helpful. However, we know now putting children or adolescents into institutions is not the way to help. A long-term psychiatric hospital is still part of the mental health system but now only for a very small number of adults with severe mental illness for whom living in the community, even with optimum support, would leave them worse off. Long-term psychiatric hospitalisation is not the right place for the mental health needs of children or adolescents.

This text is taken from *Goodna Girls: A History of Children in a Queensland Mental Asylum*, by Adele Chynoweth, published 2020 by ANU Press, The Australian National University, Canberra, Australia.

doi.org/10.22459/GG.2020.07