Management of problematic alcohol users by the mental health system in Western Australia

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by Greg Swensen - Background paper (draft)

1 Overview

This paper considers the function the mental health system has performed in Western Australia (WA) in relation to the treatment of those with mental disorders associated with the acute and chronic effects of the use of alcohol. The research considers how from the earliest time, soon after its establishment as a colony, for over a period of about 150 years, the mental health system performed a key role of institutional based form of management with respect to alcohol-caused mental disorders.

Whilst the paper is concerned with the management of alcohol-caused disorders, it is important to recognise that the marked shift from institutional to community-based modalities of treatment of a broad range of mental disorders, was also pivotal in the adoption of policies in the mid 1970s to establish a separate specialist treatment system for managing the problematic use of alcohol and other drugs.

The 'deinstitutionalisation' of mental hospitals which commenced in earnest in the 1960s, occurred because of changing attitudes towards mental illness, the eschewing by psychiatrists of the reliance on involuntary treatment and the development of effective psychotropic medications which obviated the need for restraint and confinement.[1]

Also, the impetus for deinstitutionalisation was the poor quality of life of those who had spent long periods of time in psychiatric institutions and associated brutalisation and degradation which had been identified.[2]

2 The impetus for social order through social control

2.1 Overview

A characteristic of colonial WA was how it established a number of interlocking and reciprocating mechanisms directed to establish social order through the custodial roles performed by the mental health and the prison systems. This was manifested with the establishment of Fremantle Prison and Fremantle asylum, in 1859 and 1865, respectively. A lesser known but important instrument social was also undertaken by poorhouses.

Fremantle Prison was constructed by the use of convict labour and for its first few years was known as the Convict Establishment as it had been originally conceived as a destination and place of residence for convicts on and following arrival. It was renamed Fremantle Prison in 1886 after it had been transferred to the colonial government, along with a number of buildings, after the cessation of transportation of convicts.

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[1] E Cunningham-Dax, 'The evolution of community psychiatry,' *Australian and New Zealand Journal of Psychiatry* 26 (1992); P Martyr, 'A brief history of forensic mental health services in Western Australia,' *Australasian Psychiatry* 25(3) (2017).

[2] Such as the findings of the Chelmsford Royal Commission chaired by Justice Slattery in the late 1980s, which exposed the activities of the infamous Dr Harry Bailey and Dr John Herron and their use of 'deep sleep therapy' over the period from the early 1960s to the late 1970s at Chelmsford Private Hospital: <https://en.wikipedia.org/wiki/Chelmsford_Royal_Commission>

In the first decade of the twentieth century in WA there was beginnings of reform, whilst still retaining the pre-eminent role of institutions, sought to ameliorate some of the harshness of these institutions, through the *Prisons Act 1903* which had reformed the *Prisons' Discipline Act 1880* relation to the conduct of prisons, as well as to provide improve the treatment of mental illness through the *Lunacy Act 1903*.[3]

As this paper is concerned with the role of the mental health system in managing consequences due to the use of alcohol, this will involve consideration of arrangements were supported by mental health practitioners to manage and treat those who experience mental health problems associated with their use of alcohol.

It will be argued how in the earliest part of the period, from the establishment of the colony of WA, the policies were to have the mental health system to perform a custodial role, to confine and separate those suffering most forms of mental disorder in asylums. This occurred if an individual's use alcohol was sufficiently disruptive to those around him or her, or resulted in a substantial level of harm through self-neglect, such that they were deemed to be an 'inebriate', which served as a proxy confirmation of a mental disorder. An 'inebriate' could then be committed by a court to a determined period of detention in a mental health facility for 'treatment.'

Even though this reliance on the mental health system operated for much of the period, by the early 1960s it began to lose support by mental health practitioners as method to treat alcohol users, who were increasingly regarded as not having a mental disorder. In response to the growing reluctance of the mental health system to continue to play this role, policy makers enacted a new piece of legislation, the *Convicted Inebriates Rehabilitation Act 1963*, so that those offenders whose offending was related to their use of alcohol, were deemed to be a 'convicted inebriate' and thereby be ordered to go into a prison facility to undergo rehabilitation and 'treatment'.

2.2 Asylums to hospitals

The term 'lunatic asylum' whilst now not in use, was one which had been used for a very long time, related to managing the mentally ill, exemplified by the London-based Royal Bethlem Royal Hospital which operated from about 1630 at place to confine and manage so-called 'lunatics'. The term 'Bedlam' stems from this era when the public were encouraged to visit and witness the circumstances of those mentally ill persons who confined as a form of public spectacle.[4]

Over the years following the establishment of the Swan River Colony in 1829 it became increasingly evident that there was a need for a separate facility to admit those with mental illnesses. Indeed, the first recorded account of a mentally ill person requiring treatment involved Dr Nicholas Langley, the appointed surgeon, who during the course of the voyage on a ship with the convoy of first settlers in 1829 became very agitated and on disembarkation became so violent he was required to be confined on the hulk of a wrecked merchant ship at Fremantle. [5]

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[3] R Virtue, 'Lunacy and social reform in Western Australia 1886-1903,' *Studies in Western Australian History* 1 (1977).
[4] https://en.wikipedia.org/wiki/Bethlem_Royal_Hospital
[5] P Maude, 'Treatment of Western Australia's mentally ill during the early colonial period, 1826 - 1865,' *Australasian Psychiatiry* 21(4) (2013).

This meant from the earlier years of the colony's settlement, the prison system performed the function of housing people with mental illness in Fremantle Jail. Before the opening of the Fremantle Asylum in 1865, as it had been recognised that mentally ill people needed to be separated from the prison system, a repurposed warehouse had been initially established as an asylum in 1857.

The symbolism and importance attached to there being an institutional system to punish and confine those who broke the law and transgressed other norms in WA, from its inception is demonstrated from the construction of the Round House in 1831, just two years after settlement.

> 'In Western Australia, the first permanent building was not a church, not an inn, nor a private house. It was a gaol. This gaol, ostensibly designed for criminals, also served as a place for the containment of lunatics.'[6]

The need for a purpose built-facility to manage of mentally ill people became a matter of greater concern to the colony after it was proclaimed a British penal colony in 1849 and started to receive convicts in 1850, a number of who were 'lunatics' in the language of that time, whose mental illness substantially impaired their social functioning.[7]

The Fremantle Asylum remained as the principal place to confine and manage those with mental illness until the construction and opening of the Claremont Hospital for the Mentally Insane in 1903, until it was closed down after the last patients were transferred to Claremont in 1909. The Claremont Hospital for the Mentally Insane was renamed the Claremont Mental Hospital in 1933 and in 1967 after the word 'Mental' was removed from its title it became known as the Claremont Hospital.

In 1972 Claremont Hospital was partially decommissioned and divided into two renamed institutions, Graylands Hospital which treated acute patients and Swanbourne Hospital which focussed on persons with psychogeriatric disorders and adult patients with developmental disabilities.

2.3 War veterans and mental illness

Initially war veterans with psychiatric disorders were admitted to the Claremont Asylum on their return from the war. However, by 1918 a separate institution, Stromness Hospital, had been constructed with Commonwealth funding provided to the State, to only treat veterans with mental illness. Stromness Hospital operated from 1918 to 1926 and after its closure, patients were transferred to Lemnos Hospital, a new purpose built facility on Stubbs Terrace in Shenton Park, which operated from 1926 to 1995.

A prevalent form mental illness, now formally recognised as being post-traumatic stress disorder (PTSD), was apparent in returning service men from World War I, which at that time was referred to as 'shell shock', although it was recognised as a form of hysteria, a disorder considered as exclusively involving women.[8]

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[6] N Hudson-Rodd and G A Farrell, 'The Round House Gaol: Western Australia's first lunatic asylum,' *Australian and New Zealand Journal of Mental Health Nursing* 7 (1998), 154.
[7] M McPherson, 'A class of utterly useless men: Convict lunatics in Western Australia,' *Studies in Western Australian History* 24 (2006).
[8] M C McDonald, M Brandt, and R Blum, 'From shell-shock to PTSD, a century of invisible war trauma', The Conversation, (4 April 2017), <http://theconversation.com/from-shell-shock-to-ptsd-a-century-of-invisible-war-trauma-74911>.

As the number of returning service men showing signs of PTSD increased, with possibly at least one in five men who developed the condition, this required changes in views about causality, which posited that 'shell shock was a disease of manhood rather than an illness that came from witnessing, being subjected to and partaking in incredible violence', because it was held:

> 'Soldiers were archetypically heroic and strong. When they came home unable to speak, walk or remember, with no physical reason for those shortcomings, the only possible explanation was personal weakness. Treatment methods were based on the idea that the soldier who had entered into war as a hero was now behaving as a coward and needed to be snapped out of it.'[9]

Since the closure of Lemnos Hospital this building in the mid 1990s it has been repurposed and used for a number of years as a community facility in conjunction with the sports grounds that lies between it and Shenton College.

The retention and repurposing of the former Lemnos Hospital can be contrasted the approach involving the buildings after the decommissioning of the former Claremont Asylum site, which had consisted of a series of separate buildings in a 160 hectare parkland setting. Following the closure of Swanbourne Hospital in the early 1980s most of these buildings were not preserved but demolished, with the exception of Graylands Hospital, which continues to operate as an acute facility on a small portion of the former site along with a special purpose high security forensic facility, the Frankland Unit, which was opened in 1993, only after prolonged protest against the location of this facility.[10]

The remainder of the former Claremont Asylum site was subdivided and sold for housing and the construction of private school by the mid 1980s. Only a small number of iconic buildings from the former Claremont Asylum site have been retained.

One of these is Montogmery Hall, built in 1904 and which still remains vacant after being sold in 2005 to a private developer. It had been an important facet of the former asylum's rehabilitative objectives, operating as a dining area, but particularly as a recreation hall, which as noted in a Wikipedia article, enabled 'visitors (to) combine with patients in social activities such as dances, dramatic performances etc.'[11] Another iconic building which has been heritage listed, is the former Administration block, now known as the Swanbourne Administration Building.[12]

2.4 Poorhouses

Poorhouses were established to provide some form of relief, begrudgingly and on a very restrictive basis, for homeless and unemployed people who were denied rations or 'outdoor relief'. The provision of 'indoor relief' involved submission to systems of discipline in both the men's and women's poorhouses, structured according to gendered arrangements, on the basis these individuals' predicaments were due to their lack of self-discipline, poor choices and weakness of will.[13]

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[9] Ibid.;
[10] Martyr, (2017).
[11] https://en.wikipedia.org/wiki/Swanbourne_Hospital
[12] http://www.environment.gov.au/cgi-bin/ahdb/search.pl?mode=place_detail;place_id=10296
[13] K Abbott and C Chesney, ''I am a poor woman': gender, poor relief and the poorhouse in late ninteenth and early twentieth century Western Australia,' *Studies in Western Australian History* 25 (2007).

The stimulus for the Female Poorhouse can be traced to earlier economic driven factors and after the cessation of the transportation of convicts in 1868, by the conversion of former convict depots into institutions to provide a place for homeless individuals.[14]

The poorhouses, such as the Mount Eliza poorhouse established on a site on Mounts Bay Road west of the city at the foot of Kings Park. (This site was subsequently sold for the construction of the Swan Brewery.) These poorhouses were run according to rule prescribed in regulations under an 1882 act concerned with the maintenance and running of poorhouses. These regulations were designed to discipline those indigent persons who sought to stay there by setting out in some detail the amount of food, daily schedules of activities and the nature of the work, punishments for failure observe rules etc.

The Mount Eliza poorhouse was replaced by a purpose-built institution further away from the city at Freshwater Bay, renamed the Old Men's Home, which opened in 1906. The Mount Eliza and other poorhouses housed a population of poor and destitute people, who had found themselves in the predicament of homelessness due to long-standing sustained use of alcohol:

> 'The Mount Eliza buildings were sold in 1908 with the exception of one wooden building which was transferred by horse and dray to the new site. For many years it housed alcoholics and other noisy patients. Known as The Bungalow', it is now the main Occupational Therapy department and is all that remains of the original depot.'[15]

We can see therefore that there was a multi-layered system of social controls existed from the inception of the Swan River Colony in 1829, well before the colony was proclaimed a British penal colony in 1849.

With the change in the role of WA to that of a penal colony, this increased the perception of increased social controls and resulted in a total of 9,720 convicts being transported from the United Kingdom (UK) between 1851 and 1868.[16]

There were similarly repressive mechanisms exercised by the criminal justice system, from provisions in the *Police Act 1892,* which imposed fixed terms of imprisonment for repeat offenders for public drunkenness.

In effect this meant the combined powers available through the criminal justice and the mental health systems over this 60 year period established a framework of coercive and punitive measures which targeted problematic users of alcohol. This system was predicated on the belief that without strict controls, the unfettered use of alcohol posed a serious risk to social order and the stability of the family.

In addition to the repressive provisions in both mental health and police legislation, provisions were also present in other legislation, which sustained an environment of control over alcohol. These included restrictions on Sunday trading hours of hotels, the closure of hotels on holidays in accordance with the Christian calendar, the creation of extended opening hours in mining regions, the exclusion of Indigenous people from gazetted towns, the prohibition of alcohol use

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[14] P Hetherington, *Paupers, poor relief and poor houses in Western Australia 1829 - 1910.* Perth, WA: University of WA Press, 2009,

[15] A T Whyntie, 'Sunset Hospital: it's history and function,' *Early Days: Journal of Royal Western Australian Historical Society* 8(5) (1981), 66.

[16] J S Battye, *Western Australia: a history from its discovery to the inauguration of the Commonwealth. Fascimile edition reprinted 1978.* Perth, WA: University of Western Australia Press, 1924

by Indigenous people in prescribed zones in the State and extended hours of trading through special classes of licenses.

The perceived threat of alcohol to social order was also reflected in other policy areas, such as in matrimonial matters, where alcoholism was a ground for divorce under the State's *Matrimonial Causes and Personal Status Code 1948* and restrictive provisions in 'native welfare' legislation, which targeted Indigenous people who were regarded as being incapable of using it safely should be prohibited from its use.

2.5 The criminal justice system

Public drunkenness and other alcohol-related law and order problems were a salient issue in WA from its earliest days; a characteristic shared with other Australian jurisdictions, who reported similar levels of social problems from high levels of alcohol use.[17]

> 'Alcoholism, drunkenness and the basic problems associated with them – such as personal misery, economic ruin and crime – have been features of Australian society since the very first days of the white man's settlement on the continent. …
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> Various writers who described the early days of the colony (of New South Wales) drew attention to the fact that "many poor settlers were ruined by the craving for liquor", that church services were rendered impossible because of the "number of drunken soldiers and convicts surrounding the outside of the place of worship", and the colony's first murder, in January 1794, was probably directly related to the theft of money to buy liquor.'[18]

It has been suggested that the scale and extent of the consumption of alcohol and high levels of drunkenness throughout Australia as a distinct feature of colonial life should be referred to not as 'a continual riot of drinking … but as a series of alcoholic spasms.'[19] Baker also quotes a commentator from the early 1880s, who attests

> 'The quantity of spirits drunk in Australia is appalling… And what about drunkenness? Statistically it is not very much worse than England, but difference lies in the class who get drunk. Here it is not merely the lower classes, but everybody that drinks. Not a few of the wealthiest and most leading citizens are well-known to be frequently drunk, though their names do not, of course, appear in the papers or in the police reports.'[20]

Over the colonial era police powers were expanded to deal with public drunkenness and other public order offences, such as occurred with the proclamation of the 1849 *Ordinance for regulation the police in Western Australia* (12th Vict. No. 20), which provided, in Order 8, that:

> 'it shall be lawful for any constable to apprehend without warrant, any person whom he shall find drunk in any street or public place in any of the said towns at any hour of the day or night, and any loose, idle, drunken, or disorderly person whom he shall find therein disturbing the public peace, or whom he shall have just cause to suspect of any evil design,

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[17] AE Dingle, 'The truly magnificent thirst: An historical survey of Australian drinking habits,' *Historical Studies* 19 (1980); A E Dingle. Drink and drinking in nineteenth century Australia: a statistical commentary Monash papers in economic history, No. 6 1978; D Kirkby, "Drinking the good life: Australia c 1880-1980," in *Alcohol: A social and cultural history*, ed. Holt MP Oxford, Berg, 2006, ; C Pearl, *Beer, glorious beer.* Melbourne, VIC: Thomas Nelson, 1969,

[18] Senate Standing Committee on Social Welfare, *Drug problems in Australia: An intoxicated society?* Canberra, ACT: Australian Government Publishing Service, 1977, 27.

[19] S J Baker, *The Australian language. Second edition.* Sydney: Currawong Publishing, 1966, 225.

[20] Ibid.;

and any person whom he shall find between sunset and sunrise lying or loitering in any street, highway, yard, or other place within the said towns, and not giving a satisfactory account of himself.'

Accounts in the popular press and scholarly writing about this era in WA confirm the heavy use of alcohol. For instance, a news item in the Perth Gazette of September 1853, referred to a list of court cases dealt with by the Perth Magistrates Court:

'The consumption of alcohol provided a release from the cares of everyday life for many of Western Australia's workers. The government responded not by dealing with the root problems but by closing public houses, increasing the duty on liquor and so on. But the heavy drinking went on, as evidenced by an article in the Perth Gazette.'[21]

A contribution in Stannage's 1981 seminal history of the State stated:

'Alcohol and social reaction to it was at the root of the crime problem in Western Australia. … This was in no way exceptional. Indeed, from the 1830s drink had been a serious community problem in Swan River. The coroners' records show that many of the "death by drowning" and "death by misadventure" cases occurred as a result of bouts of drunkenness …

Derelict women and men wandered drunken and homeless through the streets of the towns before being arrested and imprisoned overnight, to be charged with being "drunk and disorderly", "resisting arrest" and so on the next day.'[22]

The Indigenous population was particularly harshly dealt with by the colonial courts, stemming from their ruthless manner by which they were forced from their traditional lands and subsequent cycles of conflict and reprisal killings by settlers, as has been documented in numerous historical accounts of these early times, [23] as well as an enduring post-colonial legacy. [24]

'For no group in the history of Australian society is the statement "the law is a vehicle of social control" more apt than for the Aborigines, for whom the white man's authoritative regulation was tyranny. Fifty per cent of cases heard by the Supreme court, Perth, before 1850 involved Aborigines.' [25]

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[21] M Aveling, ed. *Westralian voices: documents in Western Australian social history.* Perth, WA: University of Western Australia Press, 1979, 79.
[22] J E Thomas, "Crime and society," in *A new history of Western Australia*, ed. Stannage CT Perth, WA, University of Western Australia Press, 1981, 642.
[23] I M Crawford, "Aboriginal cultures in Western Australia," ibid., ed. C T Stannage ; N Green, "Aborigines and white settlers in the nineteenth century," ibid. ; ———, *Broken spears: Aboriginals and Europeans in the southwest of Australia.* Cottesloe, WA: Focus Education Services, 1984, ; ———. John Ramsden Wollaston and the Aboriginal experience York, WA: Holy Trinity Church York Society, 1988.
[24] G C Bolton "Black and white after 1897," in *A new history of Western Australia*, ed. C T Stannage Perth, WA, University of Western Australia Press, 1981, ; P Biskup, 'White-Aboriginal relations in Western Australia: an overview,' *Comparative Studies in Society & History* 10(4) (1968); ———, *Not slaves, not citizens: the Aboriginal problem in Western Australia 1898-1954.* St Lucia, QLD: University of Queensland Press, 1973, ; R M Berndt and C H Berndt, eds., *Aborigines of the West: their past and their present.* Perth, WA: University of Western Australia Press, 1979,
[25] Perth Gazette, "Relations with Aborigines (February 1833)," in *Westralian voices: documents in Western Australian social history*, ed. M Aveling Perth, WA, University of Western Australia Press, 1979, 96.

The management of convicts on their arrival was largely the responsibility of the Enrolled Pensioner Force, who between 1850 and 1880 had enforced law and order as part of their role concerned with oversight of convicts, including for another decade or so after 1868, after no more convicts were received.[26] Their role included the management of convicts housed in depots in locations around the metropolitan area and districts outside of Perth and overseeing on a day-to-day basis those engaged in work gangs.

Whilst the influx of this large numbers of convicts amplified concerns about law and order it is clear that well before their arrival in 1850 that rigorous punishments were an integral part of measures utilised by the criminal justice system to deal with those who broke the law.

However, whilst the transportation of the convicts was justified as yielding economic benefits by overcoming the colony's severe shortage of labour to undertake the construction of roads and public buildings and as a source of labour in the agricultural and pastoral industries, it has been noted that this also brought with social costs:

> 'Lack of infrastructure and the unavailability of skilled and unskilled labour to provide this resulted in the necessity for cheap convict labour. The transportation of convicts brought with it an increase in the percentage of people with a mental illness in the general population as well as a need for appropriate accommodation and treatment options.'[27]

2.6 Treatment of inebriates

The *Lunacy Act 1871 Act* was replaced by the *Lunacy Act 1903*. However, as will be outlined the 1903 legislation did not resolve the concern with the earlier version of the Lunacy Act which it repealed, as this 'criminalised public manifestations of mental illness and involved medical practitioners in its detection and management, (as) Part III … provided for the management of 'dangerous and criminal lunatics", including detention by order of the Colonial Secretary.' [28]

A feature of the *Lunacy Act 1903* was that it included a specific section in Part IV, that dealt specifically with the committal and management of 'habitual drunkards' in asylums. This enabled a habitual drunkard to be detained on a court order for a period of up to 12 months for treatment in a 'hospital for the insane', provided that the inebriate was not detained in a ward in such a hospital that was also used to treat 'lunatics', by one of three alternative methods set out in Section 26:

(1) By the habitual drunkard himself declaring that he is willing to submit to curative treatment under the order or the Court; or

(2) By the parent, husband, wife, child, or friend of such habitual drunkard, in cases -

(a) Where such person is suffering or has been recently suffering from delirium tremens or other dangerous physical effects or habitual drunkenness; or
(b) Where such person, through habitual drunkenness, has recently been wasting his means and been neglecting his business or insufficiently providing for his family, or a wife has been wasting the means of her husband; or

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[26] F H Broomhall, *The veterans: A history of the Enrolled Pensioner Force in Western Australia 1850-1880.* Victoria Park, WA: Hesperian Press, 1989,
[27] Maude, (2013), 401.
[28] Martyr, (2017), 297.

(c) Where such person has recently, under the influence of drink, used or threatened violence towards himself or any member or his family.[29]

Some ten years later, Part IV was repealed and subsumed into the *Inebriates Act 1912*, which continued and enabled the committal of 'inebriates' to mental health institutions (asylums). Compared to the earlier legislation, this *Inebriates Act 1912* had a potentially broader ambit in that it defined an inebriate as "a person who habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess".

This act worked on the basis that a court could make an order for the person to be committed for up to 12 months in institutions for the 'reception, care, control and treatment of inebriates', which enabled existing psychiatric facilities to be gazetted under the *Inebriates Act 1912*. The act provided for further periods of committal, each of up to 12 months, to be ordered on three possible grounds: (a) by written application by the inebriate themselves, or (b) their spouse, or parent, or a sibling or an adult son or daughter or business partner, or (c) by a police officer.

The *Inebriates Act 1912* also provided other avenues by which a person could be committed for up to 12 months to an 'institution established for convicted inebriates', which meant that the legislation had a broad scope of application to the problematic use of alcohol. This included a court if satisfied a person who had been convicted either summarily or by indictment for an offence where drunkenness was 'an element or contributing cause of the offence' was an inebriate. (Section 7).

Furthermore, this legislation could have in effect enable a protective service to provide to drunk, ie intoxicated people. If this intent of the act was implemented, it would have been a very innovative provision, as it was not until the decriminalisation of drunkenness in 1980 in WA that sobering up centres were established. Part of Section 8 bears repeating -

8. (1) Any person arrested for drunkenness and visibly suffering from the effects thereof shall be kept under supervision, and supplied with adequate warmth and nourishment, and any necessary medical attendance.

(2) If any such person arrested for drunkenness is convicted for such offence and sentenced to imprisonment, it shall be without hard labour.

(3) If there is an institution to which such person can be conveniently committed, he shall not be committed to a prison, but shall be committed to the institution, and in such case, he may be lawfully taken to and detained in the institution for the term of his sentence, and for the purposes of such detention shall be deemed an inebriate:

Provided that any such person shall during his detention be kept in some portion of the Institution set apart for the reception of such persons.

(4) If such person is committed to a prison or police gaol, he shall be kept under supervision, and supplied with adequate warmth and nourishment, and any necessary medical attendance.

There were also some other innovative provisions in this legislation, which also until very recently in this State were again formally adopted as methods for managing those appearing before the courts with alcohol and other drug problems. Section 12 provided that upon release of an inebriate from the institution to which they had been committed, that as a condition of the license for release, that a further term of court oversight could be imposed, 'that the licensee

[29] Section 26, *Lunacy Act 1903*.

shall for a period therein specified, not exceeding twelve months, be of good behaviour, and abstain from taking or using any intoxicating liquor or intoxicating or narcotic drugs.'

It is quite likely that these provisions in the *Inebriates Act 1912* concerning the protective management of drunk people and the imposition of an extended period of post release supervision, have remained largely unknown.

Initially, up until 1918, male inebriates were sent to an inebriates section at a farm-based psychiatric facility, Whitby Falls, south of the Perth metropolitan area. Females were sent to Greenplace, a metropolitan facility which opened in 1916. However, after closure of the inebriates section at Whitby Falls in July 1918, males as well as females, could be ordered under the *Lunacy Act 1903* to an 'inebriate homes' or to the Claremont Asylum. Two small inebriate homes were operated by the Salvation Army up to late 1920s and after their closure, the only option was committal to the Claremont Asylum.

People with alcohol related mental disorders could also be admitted voluntarily or committed to the Perth Public Hospital, which had opened its Mental Health Ward in 1908, believed to be the first such unit in a public hospital in Australia at that time. [30] This also provided inpatient short term stay and assessment facility for the reception of those suffering from a variety of acute mental disorders, which also included limited numbers of individuals who required detoxification, referred to at the time as "drying out", as they may have been alcohol dependent.

However, the Perth Public Hospital had for some years played a significant role in managing those affected by alcohol involve acute as well as chronic consequence of the use of alcohol, from when it opened 1855 and up to 1894 when it was known as the Colonial Hospital. It was renamed the Perth Public Hospital in 1894, then renamed again, as the Perth Hospital in 1921 and since 1946 has been known as Royal Perth Hospital (RPH).[31]

As the data relied upon in this paper is only based on admissions to the State's psychiatric hospitals, as outlined in the methodology section, if the data concerning alcohol-related admissions to the Perth Public Hospital was included, if broken down in the hospital's annual reports, this would provide a more complete understanding of the magnitude impact of problematic alcohol use on the health system in the period leading up to World War I and up to the opening of Healthcote Hospital (see below). For instance, it has been noted that at the turn of the twentieth century

> 'a growing number of Western Australians were brought to a hospital bed by acute and chronic alcoholism. From twenty-two in 1900-01 the number grew to 112 by 1905-06 and stood at 176 in 1910-11, momentarily topping typhoid and diphtheria as the single largest cause of admission of patients. It could not have helped the Hospital's image in the eyes of either respectable working-class patients or potential donors of financial support, that in some years between 5 and 8 per cent of its male inpatients were alcoholics. As for the outpatients' ward, Christmas in particular was noted as a time when drunks were likely to stagger through its doors to seek medical solace for injuries received and given.' [32]

A parallel system for treating mental illness in WA, including alcohol-related mental disorders, evolved after the establishment of the 'Heathcote Reception Home' in February 1929. The differences between this new inpatient facility and the stigmatised Claremont Asylum, which

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[30] Cunningham-Dax, (1992), 296.
[31] G C Bolton and P Joske, *History of Royal Perth Hospital.* Perth, WA: University of Western Australia Press, 1982,
[32] Ibid., 80-81;

operated under the *Lunacy Act 1903*, was emphasised as Heathcote was established under a separate statute, the *Mental Treatment Act 1927*, which premised treatment of those with mental illness by the voluntary admission.

Thus, the effect of the operation of the *Mental Treatment Act 1927* and the *Inebriates Act 1912* meant that indigent and less well-off individuals with alcohol-related mental illness were likely to be committed to the Claremont Asylum under the principles in the *Lunacy Act 1903*, whereas those admitted to Heathcote were voluntary admissions under the *Mental Treatment Act 1927*. In addition to these two streams for psychiatric-based treatment of alcohol-related mental illness, there also existed the possibility that a person could have been admitted to the Perth Public Hospital,

The history of the *Mental Treatment Act 1927* is of interest, in that evolved from an earlier piece of legislation, the *Mental Treatment Act 1917,* which had been passed for a specific purpose and that its benefits were confined to a small group in the community. The *Mental Treatment Act 1917* was specifically enacted to undertake the separate treatment World War I veterans with a mental illness in a standalone facility, Lemnos Hospital, as otherwise it was considered this group of returned service personnel would have being stigmatised if they had been admitted to Claremont Asylum.

3 Administrative and departmental arrangements

Because the colony adopted the UK *Lunacy Act 1845*, it was not until the *Lunacy Act 1871* was passed that WA have a local legislative framework which codified the powers and arrangements for managing those requiring detention and treatment, described in the language of the time as 'lunatics'.

At the beginning of the twentieth century the *Lunacy Act 1903* was enacted, was as discussed earlier, included a section specifically concerned with 'inebriates' and this legislative framework remained in force, with some amendments until it was replaced by the *Mental Health Act 1962*, which came into force in July 1966.

In 1906 the Public Health Department (PHD) was amalgamated with the Medical Department, which had oversight of mental health facilities, into one structure the PHD, which remained in place until 1934, when the Mental Hospital Department was established as a separate entity.

The Mental Hospital Department operated from 1934 to 1954, when a separate quasi-department, called WA Mental Health Services (MHS) was created in 1954, which oversaw the State's legislation provisions and responsibilities for treating mental illness. The MHS remained as a separate administrative entity within the overall health portfolio and reported directly to the Minister for Health.

Also, at this time the Medical Department was administratively separated from the PHD in 1956, which remained until 1979. In 1979 the Medical Department was reabsorbed into the PHD, which was a short-lived arrangement as in April 1981 new arrangements occurred which formed the Department of Hospitals and Allied Services, which existed along with the PHD. However, in May 1984, a much larger departmental structure was created, the Health Department of WA, which absorbed the MHS, the PHD and the Department of Hospitals and Allied Services. This arrangement has continued up to the present.

In spite of concerns by those who administered the mental health system in WA about the treatment and community perceptions of mental illness and were successful in change the name of the Claremont complex of buildings from being an asylum to a hospital, it was not until 1947

that the statutory title of the Inspector General of the Insane was changed by amendment to 'Inspector General of Mental Hospitals'.[33]

The annual first report on the operations of the Fremantle Lunatic Asylum, the State's only established inpatient facility at that time, was issued by the Superintending Medical Officer for the year 1899. A new title, the Inspector General of the Insane was created in the *Lunacy Act 1903* and accordingly reports were issued by the Inspector General of the Insane, from 1903 up to 1945/1946 annual report.

After World War II a change in the title to Inspector General of Mental Hospitals occurred, which meant annual reports from 1946/1947 to 1952/1953 were issued by the Inspector General of Mental Hospitals. The Mental Hospitals Department was established in January 1950 and this title was retained until December 1953, when department was renamed the Mental Health Services Department.

Whilst later the department was simply referred to as the Mental Health Services (MHS), the full name of the Mental Health Services Department remained until the MHS was absorbed into the Health Department in 1984.

As the title of 'Inspector General' was retained, from 1953/1954 to 1960/1961 annual reports were issued by the Inspector General of Mental Health Services. The term 'Inspector General' was replaced by the term 'Director' by the *Mental Health Act 1962*. This act was responsible for wide ranging reforms, including the adoption of the term 'Approved hospitals' in place of the pejorative term 'Hospitals for the Insane'.[34]

From 1961/1962 up to 1964/1965 annual reports were issued by the Director of Mental Health Services. Commencing with the 1965/1966 report up to the Department's last report in 1983/1984, annual reports were published as the annual reports of the Mental Health Services.

4 Methodology and definitions

4.1 Overview

It should be understood that different terms and concepts have been used at different times over the period being studied which changes in improved medical knowledge and community understanding as to the nature of alcohol-caused mental disorders.

As much as possible contemporary terms will be used to ensure consistency over time in meaning, with appropriate additional explanatory text included to identify potential misunderstanding that could occur in relation to using contemporary terminology to refer to concepts and terms which may no longer be in current or accepted use.

For example, the term 'alcoholic' was one used in earlier times by clinicians as well as the wider community, though its use is no longer considered acceptable as it has a pejorative meaning by implying individual blame and weakness which can have potent social consequences. In the example of alcoholic, its use has been replaced by the term 'alcohol dependent', at least by clinicians and other specialist providers, as it more accurately describes the associated physiological characteristics of the condition of 'alcoholism' and approaches to treatment.

[33] A S Ellis, *Eloquent testimony: The story of the mental health services in Western Australia 1830-1975.* Perth, WA: University of Western Australia Press, 1984, 105.
[34] Ibid., 129;

The basis for admission to the mental health system was framed around the existence of an identifiable mental disorder, though over time the meaning and description of relevant disorders has changed.

It is important to understand the interaction, overlap and changes that have occurred involving the role of the hospital system, mental health services and specialist treatment services in treating those with alcohol, as well as other drug problems.

Whereas up to the mid 1970s the mental health system performed a major role in detoxifying or 'drying out' alcohol dependent individuals, following the establishment of the Alcohol and Drug Authority (ADA) in 1974, alcohol dependent persons were voluntarily admitted to the ADA's inpatient detoxification hospital.

However, it should be appreciated that those admitted to a short stay detoxification program are part of a larger population of those admitted to private and public hospitals due to illnesses and conditions caused by alcohol. This can involve an admission for an acute alcohol-related condition such as poisoning, an injury such as a motor vehicle accident when an individual was intoxicated or alcohol affected or because of a medical condition such as liver disease which is a consequence of the chronic use of alcohol.

In addition to these medical conditions, there are also a number of mental disorders which occur because of the long-term use of alcohol, such as Korsakov's psychosis or a neuropathy which has resulted in permanent neurological harm. These disorders may result in an individual being admitted to a specialist mental health unit or ward in a public or private hospital or to Graylands Hospital, the State's psychiatric inpatient facility.

The history of the classification of diseases and medical conditions is an important consideration in understanding how alcohol-related medical conditions and disorders have been identified and treated by the general hospital system as well as the mental health system. The rise and expansion in the detail in the nature and classification of health conditions informs a range of purposes of the health system, such as supporting epidemiological research to prevent conditions, to improve the provision of targeted care and treatment and to measure long term outcomes associated with different policies.

It is necessary to provide an overview of the classification systems that have been used by WA to identify and classify the form of alcohol-related and other types of mental disorders that have resulted in a person being admitted for treatment in an inpatient facility.

4.2 The ICD system

The International Classification of Diseases (ICD) is used to classify all admissions to all hospitals in WA and all other Australian jurisdictions. Also, as this system has been adopted in many other jurisdictions, it means comparisons can be made between Australians jurisdictions and with other countries.

The feature of the ICD is that classifies the cause of all diseases and illnesses which have involved hospitalisation (ie morbidity) as well as cause death (ie mortality). This is done by a clinician assigning a primary cause at the point in the time when a person is discharged from hospital. As multiple codes are assigned to each particular hospital episode, consisting of a primary diagnosis code plus sub-codes which classify underlying conditions, the ICD system has the potential to measure both direct and indirect health-related consequences of the use of alcohol.

The current system of the International Classification of Diseases (ICD), which has been overseen by the World Health Organisation (WHO) since 1948, was initially developed in 1893 by Dr Jacques Bertillon.[35] This system was gradually adopted by a number countries and gained formal recognition following a recommendation by the American Public Health Association in 1898 for it to be adopted in North America to distinguish general diseases and those which involved a specific organ or were located in a particular site in the body.

In its early form the ICD system was developed as the International Classification of Causes of Death and revised every ten years after the first international conference in 1900. However, by 1948, when the Sixth Revision was released, it had expanded into a two-volume publication, its ongoing development became the responsibility of the WHO, who produced the Seventh Revision in 1957 and the Eight Revision in 1968. The Ninth Revision was released in 1975 and the Tenth Revision was released in 1990.

The ICD system has a range of uses, such as to identify patterns of diseases and illnesses which impact on the health system, as well as being used to undertake research related to specify issues, such as to determine health consequences due to the use of alcohol by measuring alcohol-related morbidity (ie hospitalisation) and mortality (ie deaths).

There are a set of ICD codes that are concerned mental disorders which are referred in shorthand as being ICD-2 for second revision, ICD-3 for the third revision and so forth: [36]

Second Revision: Codes 56, 59 and 68 (from 1910 to 1921)
Third Revision: Codes 66, 68 and 77 (from 1922 to 1927)
Fourth Revision: Codes 66, 68, 77 and 84a (from 1931 to 1939)
Fifth Revision: Codes 77, 79b, 84a, 84b and 84c (from 1940 to 1949)
Sixth Revision: Codes 300 to 326 (from1950 to 1957)
Seventh Revision: Codes 300 to 326 (from 1958 to 1967)
Eight Revision: Codes 290 to 315 (from 1968 to 1978)
Ninth Revision: Codes 290 to 319 (from 1979 to 1998)
Tenth revision: Codes F0 to F09 (from 1999 to present)

Within the broad level of these codes, there are codes and sub-codes used to describe and identify specific alcohol related mental disorders. For example, in ICD10, in Chapter V, Mental and behavioural disorders,[37] there are 10 groups of disorders:

F0: Organic, including symptomatic, mental disorders
F1: Mental and behavioural disorders due to use of psychoactive substances
F2: Schizophrenia, schizotypal and delusional disorders
F3: Mood [affective] disorders
F4: Neurotic, stress-related and somatoform disorders
F5: Behavioural syndromes associated with physiological disturbances and physical factors
F6: Disorders of personality and behaviour in adult persons
F7: Mental retardation
F8: Disorders of psychological development
F9: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

[35] http://www.wolfbane.com/icd/index.html; E T d'Espaignet et al. Trends in Australian mortality 1921 – 1988 Canberra, ACT: Australian Institute of Health and Welfare, 1991. Appendix A.
[36] Ibid.;
[37] Ibid., Appendix A; Appendix A

The codes in ICD-10 can be expressed at a number of levels, depending on the level of complexity that may be required. For instance, at a 2 digit level Chapter V would be referred to as covering codes F0 to F9, with mental disorders due to the use of psychoactive substances listed as "F1".

At the 3 digit level Chapter V would be referred to as covering codes F00 to F09, with mental disorders due to the use of psychoactive substances listed as "F10 to F19", which would be broken down into:

F10: Mental and behavioural disorders due to use of alcohol
F11: Mental and behavioural disorders due to use of opioids
F12: Mental and behavioural disorders due to use of cannabinoids
F13: Mental and behavioural disorders due to use of sedatives or hypnotics
F14: Mental and behavioural disorders due to use of cocaine
F15: Mental and behavioural disorders due to use of other stimulants, including caffeine
F16: Mental and behavioural disorders due to use of hallucinogens
F17: Mental and behavioural disorders due to use of tobacco
F18: Mental and behavioural disorders due to use of volatile solvents
F19: Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

At the 4 digit level Chapter V would be referred to as covering codes F000 to F099, with mental disorders due to the psychoactive use of substances listed as "F10.0 to F19.0". At the fourth digit level mental disorders due to the use of alcohol (F10) would be broken down into:

F10.0: Acute intoxication
F10.1: Harmful use
F10.2: Dependence syndrome
F10.3: Withdrawal state
F10.4: Withdrawal state with delirium
F10.5: Psychotic disorder
F10.6: Amnesic syndrome
F10.7: Residual and late-onset psychotic disorder
F10.8: Other mental and behavioural disorders
F10.9: Unspecified mental and behavioural disorder

Furthermore, in addition to a primary diagnostic code which can be assigned at the 4 digit level, for each admission additional sub-codes may be included which identify conditions wholly caused by alcohol, viz: alcoholic poisoning (X45, Y15, T51.0, T51.1, T51.9), alcohol polyneuropathy (G62.1), alcoholic gastritis (K29.2) and alcoholic liver cirrhosis (K70). [38]

This means that in ICD-10, for instance, to identify the existence of alcohol-related disorder, we need to examine diagnostic codes to a 4 digit code level. The F10 code group also groups closely related disorders to more conveniently describe them, for example "alcoholic psychosis" (F10.3 – F10.9), "alcohol dependence" (F10.2) and "alcohol abuse" (F10.0, F10.1).

Additional detail is provided in ICD-10-AM, the AM referring to 'Australian modification', which was published in 2008 by the National Centre for Classification in Health. ICD-10-AM was adopted in WA from 2010.

[38] T Chikritzhs et al., *Alcohol-related codes: mapping ICD-9 to ICD-10.* Perth, WA: National Drug Research Institute, Curtin University, 2002,

There are detailed rules contained in ICD-10-AM in relation to the coding protocols. For instance, Chapter 5 in ICD-10-AM refers to three broad categories of disorders due to the use of alcohol, other drugs and tobacco – 'acute intoxication', 'harmful use' and 'dependence'. These are differentiated from each order in accordance to the principles contained in the descriptive text in published manuals which reproduce definitions published by the World Health Organisation monograph in 1992, when ICD-10 was released: [39]

> 'Acute intoxication
> A condition that follows the administration of a psychoactive substance resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psychophysiological functions and responses. The disturbances are directly related to the acute pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen.
>
> Harmful use
> A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of psychoactive substances) or mental (eg episodes of depressive disorder secondary to heavy consumption of alcohol) . . .. Harmful use should not be diagnosed if dependence syndrome, a psychotic disorder, or another specific form of drug-or alcohol-related disorder is present for the same substance in the same time period.
>
> Dependence syndrome
> A cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance and sometimes a physical withdrawal state.'

The following illustrative text from the ICD-10-AM differentiates each category and to ensure appropriate codes are used:[40]

> Alcohol use disorders
> Descriptions such as 'drinker', 'social drinker' or 'heavy drinker' should not be coded, because levels of alcohol consumption and its effect on an individual is a subjective judgement and a specified level may affect individuals in different ways. Therefore, the available codes below should be assigned only when documentation is provided to classify to one of the following codes:
>
> Fl0.0 Mental and behavioural disorders due to use of alcohol, acute intoxication
> Fl0.l Mental and behavioural disorders due to use of alcohol, harmful use
> Fl0.2 Mental and behavioural disorders due to use of alcohol, dependence syndrome
> Z72.1 Alcohol use
> Z86.41 Personal history of alcohol use disorder'

The reference above to additional 'Z' codes requires clarification. These are codes located in Chapter 21 of the ICD-10-AM manual, Factors influencing health status and contact with health services.

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[39] National Centre for Classification in Health. Australian coding standards for ICD-10-AM and ACHI. The International statistical classification of diseases and related health problems, tenth revision, Australian modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI). July 2008, 115.
[40] p. 117.

The Z codes mean the ICD-10 code system can identify the involvement of social factors in the aetiology of a medical or health condition. Thus, the descriptive text in sub-section Z72, Problems related to lifestyle, points out that;

> 'Hazardous use is a pattern of substance use that increases the risk of harmful consequences for the user. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user.'[41]

The Z72 category refers to a spectrum of lifestyle factors, for example, hazardous use of tobacco (Z72.0), hazardous use of alcohol (Z72.1), lack of physical exercise (Z72.3) and gambling and betting (Z72.6), which may have important adverse public health impacts.

The other additional Z code which may be assigned as a secondary diagnosis, is Z86.41, Personal history of alcohol use disorder. However, the coding manual specifies that this may not be assigned if the code F10.2 (ie current alcohol dependence) has been assigned.

4.3 The HMDS

The Hospital Morbidity Data System (HMDS) was established on January 1, 1971 to record short-term hospitalisation in WA, involving both public hospitals (admitting both public and private patients) and private hospitals (admitting only private patients). It also included the Repatriation General Hospital, the State's only Commonwealth veteran's hospital, Hollywood Hospital in Nedlands. (This hospital was closed and sold to a private hospital in the mid 1980s, which now operates as Hollywood Private Hospital, who continue to provide a Commonwealth-funded service to veterans.)

The decision was made at the inception of the HMDS in 1971 to adopt the practice that had been in use in the UK since 1968, where both the 8th Revision of the International Classification of Diseases and the Code of Surgical Operations (CSO) of the General Register Office of England and Wales were used to code and classify admissions. The CSO which had been reprinted and reissued by the Commonwealth Department of Health in 1968 for use throughout Australia by the States to improve the quality of hospital statistics.

As a number of different systems have been used to code and classify admissions to WA hospitals, this means data may not be comparable over the period of time since 1971 up to the present because of changes in definitions and refinements in categories of illnesses and conditions.

The HMDS used both ICD-8 and the CSO between 1971 and up to 1978 and then adopted the ICD-9 and the International Classification of Procedures in Medicine (ICPM), which had been published by the World Health Organisation in 1975, for the period 1979 to 1981.[42]

In relation to alcohol related morbidity, as the HMDS is built around internationally validated ICD codes and sub-codes, this means since the early 1970s in this State detailed information exists to identify those illnesses and conditions which are directly as well as indirectly attributable to the consumption of alcohol. Furthermore, as the scope of the ICD encompasses a

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[41] p. 529.

[42] Holman CDJ & Brooks B. Inpatient hospital morbidity in Western Australia 1971 – 1981: An analysis of principal conditions treated, medical and surgical procedures and hospital bed days. Position paper No. 2. Perth, WA, Steering Committee on the Review of Health Promotion and Health Education in Western Australia, Public Health Department, 5.

wide spectrum of morbidity, this means as the HMDS contains very comprehensive and extensive data as it records (inpatient) covering admissions to teaching, general hospitals and private hospitals, as well as to psychiatric hospitals and psychiatric wards.

Since the adoption of the computerisation of data in the HMDS in 1 January 1968[43] marks the period from when information related to specific conditions and treatment outcomes, identifiable through ICD codes assigned at discharge, has become accessible and driven research into patterns of diseases and illnesses related to specific issues, such as the use of alcohol, in WA.

In relation to data concerning admissions to mental health facilities, it is to explain the reason for complexity exists in relation to understanding the historical data contained in appendices in departmental annual reports published by the MHS and predecessor departments up to 1978/1979. These annual reports contain detailed aggregated data concerning each episode of inpatient treatment. How an admission was classified was determined to the reason for admission to each of the State's psychiatric hospitals, according to the classification system that was followed at that time.

It is necessary to refer to these hybrid systems as it is relevant to understanding how the data concerning alcohol-related admissions has been compiled and relied upon in this research before the adoption of the HMDS system to code admissions to mental health facilities.

Over the period covered by the 1903 to 1969/1970 annual reports, a number of systems were adopted to classify admissions into categories of 'causes of insanity', some of which were indicative as caused by alcohol. Whilst the classification used in earlier reports is foreign to a modern audience, it does encompass sub categories which refer to historically well understood alcohol-related conditions.

For example, the 1903 report recorded a total of 155 (118 male and 37 female) admissions during the year which were broken down into by 'Causes of insanity', with causes grouped according to whether they were 'Moral' or 'Physical' causes.

The Moral group had six sub-categories of causes - Solitary life, Love affairs, Mental anxiety (business), Mental anxiety (domestic), Overwork, Religious excitement and Shock.

The Physical group had 15 sub-categories of causes – Accident, Congenital, Epilepsy, Heredity, Intemperance (alcohol), Intemperance (opium), Ill health, Masturbation, Puerperal state, Privation, Previous attacks, Senility, Sexual excess, Sunstroke, Venereal disease and Unknown.

This classification of causes into the two categories of moral and physical causes was used for a number of years, up to 1916, although in the 1909 report the cause of 'Intemperance' was replaced by 'Alcohol' and additional causes were included in the Physical category.

The disaggregation of perceived causes of insanity into being either Moral or Physical in origin was continued over a number of the annual reports. In the 1917 annual report a new cause appeared, 'War strain', included in the Physical category. In the 1920 annual report for the first time a breakdown by gender and whether the condition was 'Predisposing' or 'Exciting' was included.

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[43] Smith DI. 'Alcohol and crime: the problem in Australia'. In Bluglass R, Bowden P & Walker N. (eds) Principles and practice of forensic psychiatry. London, UK, Churchill Livingstone, 1990, 947 – 951.

In the 1929/1930 annual report (ie patient data for the 1929 calendar year), a revised schema for classifying admissions to the Claremont Asylum was adopted, a so-called 'Form of mental disease' schemata.

However, the approach of classifying causes into the two categories of moral and physical causes, which had been the practice since 1903, continued to be used to classify the causes of mental disorder for admissions to the Heathcote Reception Home, which had opened on 22 February 1929.

A key distinction between admissions to the Claremont Asylum and Heathcote was that the latter operated under different legislation, the *Mental Treatment Act 1927*, which did not require that patients be committed, but were voluntary admissions.

Prior to the opening of Heathcote, the only inpatient psychiatric facility which admitted voluntary patients was the Mental Health Ward at Perth Public Hospital which had been opened in 1909. As noted in the Inspector General of Insane's 1929/1930 annual report:

> 'This ward, which was opened in 1909, fulfilled a most useful purpose in the 20 years of its existence, but owing to the lack of space for the exercise of patients, the enclosed surroundings, its position, and the increasing number of patients, it became inadequate and unsuitable for its purpose.
>
> There is difficulty in attributing an etiological factor for all patients. A number of the patients who were admitted had no friends, and it was found difficult to get a satisfactory history from the patient. This accounts for the large number of cases whose causation has not been definitely attributed.'[44]

Because the state's mental health system had two pathways of admission, either by committal to Claremont Asylum according to the criteria in the *Lunacy Act* or by voluntary admission into Heathcote Hospital (technically called Heathcote Reception Home) under the *Mental Treatment Act*, this resulted in a bifurcated system for recording admissions depending on the hospital involved up until 1939.

After 1939/1940 all mental hospitals in the State used a common system to record admissions, based on the 'Form of mental disorder' schemata. In relation to alcohol-caused mental disorders, under this system these were classified as being 'Chronic alcoholism', 'Confusional state – alcoholic, 'Delirium tremens (DTs)', 'Korsakov's psychosis', 'Alcoholic hallucinosis' and 'Alcoholism and alcoholic psychosis'.

In the 1963/1964 annual report the MHS adopted a new classification scheme to record admissions. For alcohol-caused mental disorders this used the categories of 'Simple drunkenness', 'Acute alcoholism', 'Simple drunkenness (with impairment)', 'DTs', 'Acute hallucinosis', 'Chronic alcoholism', Simple alcoholism (with impairment)', 'Problem drinking (with impairment)', Korsakov's psychosis' and 'Wernicke's encephalopathy'.

In 1968 admissions of alcohol-caused mental disorders to all hospitals in WA, ie mental hospitals or to a psychiatric ward in a general hospital, were coded according to the ICD 8 system. This means it is only possible to measure the impact of the problematic use of alcohol in this State from the 1967/1968 financial year according to the ICD system and prior to that date according to the various hybrid systems developed by the MHS.

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[44] Annual report, Inspector General of the Insane, 1929/1930, 4.

Under ICD 8, alcohol-caused mental disorders were classified as being 'DTs' (code 291.0), 'Korsakov's psychosis' (code 291.1), 'Other alcoholic psychosis' (code 291.2), 'Alcoholic paranoia' (code 291.3), 'Alcohol dementia' (code 291.4), 'Other and other unspecified psychosis' (code 291.9), 'Episodic excessive drinking' (code 303.0), 'Habitual excessive drinking' (code 303.1), 'Alcoholic addiction' (code 303.2) and 'Other and other unspecified dependence" (code 303.9).

Under ICD 9, which was applied to admissions from 1979, alcohol-caused mental disorders were classified as 'Alcohol psychosis' (code 291), 'Dependence' (code 303) and 'Non-dependent abuse' (code 305.0).

A new version of the ICD system, ICD 10-CM was applied to admissions from July 2000 (backdated to 1999), which classified alcohol-caused mental disorders as 'Alcoholic psychosis' (codes F10.3 – F10.9), 'Dependence (code F10.2), 'Non-dependent abuse' (code F10.1) and 'Acute intoxication' (code F10.0).

4.4 The DSM system

Commentary is also necessary in relation to the use of the DSM system for classifying mental disorders. Although the Diagnostic and Statistical Manual of Mental Disorders (DSM) is specifically used in the classification of those who have attended a mental health facility, as it overlaps with the ICD system, it is an alternative approach to classifying mental disorders. It should be noted the DSM and ICD systems have been synchronised over recent years such that they share some of the same conceptual principles in relation the classification of alcohol-related mental disorders.

An advantage of the DSM is that can also classify outpatient attendances at mental health clinics, which is not possible under the ICD system as it has been designed to record and classify inpatient admissions at hospitals. The DSM is produced by the American Psychiatric Association (APA) and has gone through five revisions since it was published for the first time in 1952.

Prior to the introduction of DSM in 1952, there were a number of attempts to establish a system to collect census and psychiatric hospital statistics. The first official attempt was the 1840 census in the United States, which used a single category, "idiocy/insanity". By the time of the US Census of 1880, the number of categories of perceived mental disorders had expanded, to a total of seven – mania, melancholia, monomania, paresis, dementia, dipsomania and epilepsy.[45]

In 1917, a Committee on Statistics created from the American Medico-Psychological Association (now known as the American Psychiatric Association) and the National Commission on Mental Hygiene, developed a new guide for mental hospitals called the Statistical Manual for the Use of Institutions for the Insane, which included 22 diagnoses. The 1917 classification of 22 diagnostic groups was progressively revised by the APA and became known as the Standard Classified Nomenclature of Disease, referred to as the "Standard".

With the advent of World War II US medical authorities realised the need to evaluate the suitability of personnel entering the armed services either as recruits or had been conscripted by comprehensively assessing psychiatric as well as medical factors. To undertake a comprehensive mental health assessment a large number of psychiatrists became involved in the selection and processing of military personnel, as well as providing treatment and rehabilitation of those who had returned from active duty with injuries.

[45] American Psychiatric Association. 'DSM: history of the manual'. http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual.

The involvement of psychiatrists in assessing and treating military personnel during the World War II period, reflected an important shift in the way psychiatric issues were classified, away from the previous approach that was heavily influenced by mental hospital based requirements, to one that dealt with those who were from the general community.

A new classification scheme was developed by a psychiatrist William Menninger, the Medical 203, which was published in 1943 as a War Department Technical Bulletin under the auspices of the Office of the Surgeon General, also adopted by the Veterans Administration with minor modification. An APA Committee on Nomenclature and Statistics was empowered to develop a version specifically for use in the United States, to standardize the diverse and confused usage of different documents.

In response to the release of ICD-6 in 1949 the APA reviewed the Medical 203, the classification system that the Veteran's Administration had developed and the criteria that had been included in the Standard. This was published in 1952 as the Diagnostic and Statistical Manual of Mental Disorders Version I, known by the acronym of DSM-I and consisted of a list of 106 mental disorders. The foreword to DSM-1 states this 'categorized mental disorders in rubrics similar to those of the Armed Forces nomenclature.'

The development of the DSM was influenced by work by the World Health Organization with the publication in 1949 of the sixth revision of the International Statistical Classification of Diseases, which included a section on mental disorders for the first time.

From the release of version I up to release of version V, the DSM underwent substantial revisions, such that its complexity has substantially grown from an original 130 page monograph to one with 297 disorders in an 886 page monograph in the fourth revision, which was published in 1994. This was reworked as a text version, referred to as DSM-IV-TR, published in 2000.

In relation to alcohol related mental disorders, in both DSM-I and DSM-II, alcoholism was classified as a subset of personality disorders, homosexuality and neuroses. However, as has been pointed out in a National Institute on Alcohol Abuse and Alcoholism publication,

> 'In response to perceived deficiencies in DSM-I and DSM-II, the Feighner criteria were developed in the 1970s to establish a research base for the diagnostic criteria of alcoholism. These criteria were the first to be based on research rather than subjective judgement and clinical experience alone. …
>
> Several years later, Edwards and Gross focussed solely on alcohol dependence. They considered essential elements of dependence to be a narrowing of the drinking repertoire, drink-seeking behaviour, tolerance, withdrawal, drinking to relieve or avoid withdrawal symptoms, subjective awareness of compulsion to drink, and a return to drinking after a period of abstinence.'

DSM-II, which was published by the American Psychiatric Association in 1968 contained three classifications for alcohol-related mental disorders, under the heading of being either psychoses associated with Organic brain syndromes (Codes 290-294), Personality disorders (Codes 301-304) or Non-psychotic organic brain syndromes (Code 309)

291	Alcoholic psychosis
291.0	Delirium tremens
291.1	Korsakov's psychosis (alcoholic)
291.2	Other alcoholic hallucinosis
291.3	Alcoholic paranoid state (alcoholic paranoia)

291.4 Acute alcoholic intoxication
291.5 Alcoholic deterioration
291.6 Pathological intoxication
291.9 Other (and unspecified) alcoholic psychosis
303 Alcoholism
303.0 Episodic excessive drinking
303.1 Habitual excessive drinking
303.2 Alcohol addiction
303.9 Other (and unspecified) alcoholism
309.13 Non psychotic organic brain syndrome (simple drunkenness)

The third edition of the DSM, released in 1980, was notable as 'the first classification system intended for clinical as well as research use that included specific diagnostic criteria for the major disorders. Most important for alcohol researchers, DSM-III also was the first classification system to present criteria for two alcohol use disorders – abuse and dependence – rather than for alcoholism alone.'[46] The release of DSM-III in 1980, which had been preceded by ICD-9, which was published in 1975 and officially adopted in 1978, reflected the recognition that the two classification systems should be coordinated. The distinction between these two systems, even though they were and continue to be closely matched, is best understood by their different uses.

> 'ICD-9 did not include diagnostic criteria or a multiaxial system largely because the primary function of this international system was to outline categories for the collection of basic health statistics. In contrast, DSM-III was developed with the additional goal of providing a medical nomenclature for clinicians and researchers. Because of dissatisfaction across all of medicine with the lack of specificity in ICD-9, a decision was made to modify it for use in the United States, resulting in ICD-9-CM (for Clinical Modification).'[47]

The 1987 revision, DSM-III-R, included a reconceptualisation of alcohol dependence to overcome the limitation of the concept in DSM-III, which it has been noted had been published 'without reference to published supporting data', by the use of criteria established the existence of the Alcohol Dependence Syndrome (ADS).[48]

> 'The ADS was conceptualised as an integration of physiological and psychological processes leading to heavy drinking that was increasingly unresponsive to external circumstances or adverse consequences. … The ADS clearly differentiated between the dependence process itself and social, legal and other consequences of heavy drinking, a distinction known as the biaxial concept.'[49]

DSM-IV, which in came into effect in 2010, the following set of diagnostic codes are used to classify alcohol related mental disorders:[50]

291.81 Alcohol Withdrawal

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[46] Hasin D. 'Classification of alcohol use disorders.' http://pubs.niaaa.nih.gov/publications/arh27-1/5-17.htm.
[47] American Psychiatric Association. 'DSM: history of the manual'. http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual.
[48] The adoption of the ADS was formalised in a World Health Organisation memorandum in 1981, 'Nomenclature and classification of drug and alcohol related problems: WHO memorandum', published in the Bulletin of the World Health Organisation, 99, 225-242.
[49] Hasin D. 'Classification of alcohol use disorders.' http://pubs.niaaa.nih.gov/publications/arh27-1/5-17.htm.
[50] From: About DSM-5. http://www.dsm5.org/ProposedRevisions/Pages/Substance-RelatedDisorders.aspx.

291.0 Alcohol Intoxication Delirium
291.0 Alcohol Withdrawal Delirium
291.2 Alcohol-Induced Persisting Dementia
291.1 Alcohol-Induced Persisting Amnestic Disorder
291.5 Alcohol-Induced Psychotic Disorder - With Delusions
291.3 Alcohol-Induced Psychotic Disorder - With Hallucinations
291.89 Alcohol-Induced Mood Disorder
291.89 Alcohol-Induced Anxiety Disorder
291.89 Alcohol-Induced Sexual Dysfunction
291.82 Alcohol-Induced Sleep Disorder
291.9 Alcohol-Related Disorder Not Otherwise Specified
303.90 Alcohol dependence
305.00 Alcohol abuse
303.00 Alcohol Intoxication

The removal of reference to the term 'addiction' from DSM-III, which was released in 1980, reflected an intention to remove the perceived pejorative terminology which had been associated with addiction. It was replaced by the terms of "dependence" and "abuse", which it has been argued proved to be "confusing and misleading" as they did not replace the "cultural baggage and stigma" that had been associated with addiction:

> "Abuse" turned out to be highly stigmatising, with drug takers being compared with other types of abusers. This was shown clearly in one trial that found patients described as "substance abusers" to health-care professionals were recommended less therapy and more punishment than when they were described as having "substance use disorders".
>
> "Dependence" too is misleading. Physical dependence occurs not only when people take addictive drugs, it can also occur with psychiatric medication. It is possible to be dependent on a substance without experiencing the full range of symptoms necessary for addiction. By confusing dependence and addiction, the DSM unfortunately added a level of stigma to an otherwise normal response to repeated doses of medication."[51]

The concordance between DSM system of classification, from the DSM-III-R in 1987 to DSM-IV in 1994 and the ICD-10, was introduced by the WHO in 1993, though it was not adopted in Australia until 1999.[52] The fifth revision, DSM-V, published in May 2013, has been criticised as it is claimed it continues the trend of proliferating diagnostic groups which occurred between 1951 and 2013.

> 'DSM's understanding of mental disorder is far more inclusive than most lay people's, trespassing into territory than may would see as belonging to neurology, paediatrics, general medicine, education or, indeed, simple human frailty. As a result critics have often accused DSM of a disease-mongering land grab or, to switch metaphors, of including bats and butterflies in its classification of birds.' [53]

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[51] Smart GL & Murphy D. 'Internet use and the DSM-5's revival of addiction.' The Conversation, 27 October 2012. https://theconversation.com/internet-use-and-the-dsm-5s-revival-of-addiction-10346
[52] Adapted from Hasin D. 'Classification of alcohol use disorders.' http://pubs.niaaa.nih.gov/publications/arh27-1/5-17.htm.
[53] Belluck PM & Carey B. 'Psychiatry's guide is out of touch with science, experts say.' New York Times, 6 May 2013. http://www.nytimes.com/2013/05/07/health/psychiatrys-new-guide-falls-short-experts-say.html

One reason for wide spread criticism of the latest version of the DSM is that DSM-V signals a shift in focus of mental health research priorities and therefore will impact on the provision of services for specific disorders.

In a statement by Dr Thomas Insel, the Director of the National Institute of Mental Health (NIMH), which oversees public funding of research, the Director outlined his view that the 'goal was to reshape the direction of psychiatric research to focus on biology, genetics and neuroscience so that scientists can define disorders by their causes, rather than their symptoms.' [54]

[54] Belluck PM & Carey B. 'Psychiatry's guide is out of touch with science, experts say.' New York Times, 6 May 2013. http://www.nytimes.com/2013/05/07/health/psychiatrys-new-guide-falls-short-experts-say.html

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