

Aboriginal People in Western Australian Mental Hospitals, 1903–1966

Philippa Martyr* and Sophie Davison

Summary. Australian surveys show that Aboriginal people are currently nearly three times more likely to report high levels of psychological distress than non-Aboriginal people, are twice as likely to be hospitalised for mental health problems, and are more likely to die as a result of a mental health-related condition. But has this always been the case? While mental health service use, in particular hospital admission, is not always indicative of the incidence and prevalence of mental illness in a population, very little is known about Aboriginal Australian involvement with mental health services since white contact. This paper seeks to create a historical profile of Aboriginal admissions to public mental health services in an Australian jurisdiction in the first half of the twentieth century, and to provide further insights into their lived experience from newspaper reports, government inquiries and oral histories.

Keywords: aboriginal Australians; mental illness; mental hospital histories; colonialism

In the last decade there has been increasing concern about the poor mental health of Aboriginal and Torres Strait Islander Australians.¹ National surveys show that Aboriginal people are nearly three times more likely to report high or very high levels of psychological distress than non-Aboriginal people; are twice as likely to be hospitalised for mental health problems; and are more likely to die as a result of a mental health-related condition.² Aboriginal Australians have continued to argue for the development of a more culturally appropriate, holistic mental health approach.³ Extensive consultation with Aboriginal groups and health services has confirmed that mental health problems should always be considered within the context of 'the impact of colonisation; trauma; loss and grief; separation from families and children; the taking away of land; and the

*Clinical Research Centre, Gascoyne House, Graylands Health Campus, Brockway Road, Mount Claremont WA 6010, Australia. E-mail: Philippa.Martyr@health.wa.gov.au.

Dr Philippa Martyr and Dr Sophie Davison both currently work for North Metropolitan Health Service, Western Australia, and they share a research interest in Aboriginal people's use of mental health services in Western Australia. They also recently collaborated on a historical clinical profile of Martin O'Meara VC (1885–1935), a war veteran permanently incapacitated by mental illness.

¹We have preserved in this article the use of contentious terms such as 'native', 'Aboriginal', 'Abo', and 'half-caste' when they appear in original documents. Current practice in Western Australia generally prefers the term 'Aboriginal people'. The term 'lunacy' and 'lunatic' are also used where they have appeared in original documents.

²Pat Dudgeon *et al.*, 'Effective Strategies to Strengthen the Mental Health and Wellbeing of Aboriginal and Torres Strait Islander People', Issues Paper 12, *Closing*

the Gap Clearinghouse (Canberra: Australian Institute of Health and Welfare, 2014); Stephen Zubrick *et al.*, 'Social Determinants of Social and Emotional Wellbeing', in P. Dudgeon, H. Milroy and R. Walker, eds, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Canberra, ACT: Department of Health and Ageing, 2014), 93–112.

³Zubrick *et al.*, 'Social Determinants', 106.

loss of culture and identity; plus the impact of social inequity, stigma, racism and ongoing losses'.⁴

In spite of the historical roots of present Aboriginal mental health issues, historical studies of the mental health and well-being of this population in Australia are almost non-existent.⁵ We know very little about Aboriginal people's patterns of mental health acuity, diagnoses, degree of involvement with services and outcomes before the 1960s. There is almost certainly data in existence, but it is spread throughout the archives and papers of a range of diverse institutions, including reserves and missions, which were run by religious or other private organisations, and the records of the various government departments charged with Aboriginal 'protection' over decades. There was little open public health focus on Aboriginal people's health and well-being in this period in Western Australia.⁶ As a result, we have only been able to draw upon partial sources, and those which only represent non-Aboriginal views of Aboriginal mental illness.

The lack of data is not just a historical problem: Black *et al.* have recently identified the serious limitations on current evidence for the present-day incidence and prevalence of psychiatric disorders among Aboriginal Australians, as well as the lack of standardised and validated methods being used to estimate these.⁷ While mental health service use is not always indicative of the incidence or prevalence of mental illness in a population, the lack of data makes it difficult to determine if increased Aboriginal involvement with mental health services is a new phenomenon, or if this has been a long-term pattern since white contact. Research that can retrieve this data and begin to construct a narrative of past Aboriginal mental health service use can inform and reshape present-day understandings of how and why Aboriginal Australians use public mental health services.

Western Australia is the largest of the six Australian states, but also the most sparsely populated. It was founded by free British settlers in 1829, but received transported convicts from 1850 to 1868. Aboriginal people in nineteenth- and twentieth-century Western Australia formed a vulnerable population that was easily targeted by a range of oppressive legislation, including an Aborigines Act of 1905 which created the position of honorary 'protectors' of Aboriginal peoples, such as police constables.⁸ Factors such as social disadvantage, cultural dislocation, trauma and loss, forced removal from family and traditional lands, alcohol and substance abuse, sexually transmitted diseases, and other issues related to colonisation, all contributed to shaping emotional health and well-

⁴Pat Swan and Beverly Raphael, *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy National Consultancy Report* (Canberra, ACT: Department of Health and Ageing, 1995).

⁵Caitlin Murray, 'The "Colouring of the Psychosis": Interpreting Insanity in the Primitive Mind', *Health and History*, 2007, 9, 7–21; Philippa Martyr, "'Behaving Wildly": Diagnoses of Lunacy among Indigenous Persons in Western Australia, 1870–1914', *Social History of Medicine*, 2010, 24, 316–33.

⁶One exception to this was the *Royal Commission to Investigate, Report and Advise upon Matters in Relation to the Condition and Treatment of Aborigines 1935* (Perth, WA: Government Printer, 1935). A good introduction to the philanthropic men-

talities of Aboriginal 'protection' is Jessie Mitchell, *In Good Faith? Governing Indigenous Australia through God, Charity and Empire, 1825–1855* (Canberra, ACT: Australian National University ePress, 2011).

⁷Emma Black *et al.*, 'A Systematic Review: Identifying the Prevalence Rates of Psychiatric Disorder in Australia's Indigenous Populations', *Australian and New Zealand Journal of Psychiatry*, 2015, 49, 412–29; see also Tom Briffa *et al.*, 'Under-ascertainment of Aboriginality in Records of Cardiovascular Disease in Hospital Morbidity and Mortality Data in Western Australia: A Record Linkage Study', *BioMedCentral Medical Research Methodology*, 2010, 10, 111–18.

⁸Martyr, "'Behaving Wildly'", 317.

being for Aboriginal people in the nineteenth and twentieth centuries, and some of these issues are still problematic for this population.⁹ With this in mind, this paper will open up the twentieth century for closer examination, which may help to shed some light on current patterns of service use.

Aboriginal People and Australia's Mental Health History

Historical studies of indigenous mental illness under European colonial rule have mostly focused on areas other than Australia, such as India, South East Asia and Oceania and Africa.¹⁰ Australia's situation is not always easily comparable to these settings, nor to that of New Zealand's Maori.¹¹ In colonial Australia, the Aboriginal population still predominantly lived in traditional hunter-gatherer societies that were clan-based with distinct language groups, and the population was also comparatively small, especially after the enormous influx of Europeans during gold rushes in the mid to late nineteenth century. The Western Australian Aboriginal population was estimated in 1901 at barely 6,000, compared to a non-Aboriginal population of 184,124.¹²

Although there were early attempts to interpret Aboriginal mental health from a white perspective, Hunter claims (and McMahon confirms) that the concept of 'Aboriginal mental health' simply did not exist in Australia before the 1950s.¹³ Given that

⁹Human Rights and Equal Opportunity Commission (Australia), *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (Canberra, ACT: Commonwealth of Australia, 1997); Zubrick et al., 'Social Determinants'.

¹⁰Waltraud Ernst, *Colonialism and Transnational Psychiatry: The Development of an Indian Mental Hospital in British India, c. 1925–1940* (London; New York: Anthem Press, 2013); James Mills, *Madness, Cannabis and Colonialism: The 'Native Only' Lunatic Asylums of British India, 1857–1900* (London: Palgrave Macmillan UK, 2000). Hans Pols, 'The Nature of the Native Mind: Contested Views of Dutch Colonial Psychiatrists in the Former Dutch East Indies', in S. Malone and M. Vaughan, eds, *Psychiatry and Empire* (London: Palgrave Macmillan, 2007), 172–96; Jacqueline Leckie, 'Islands, Communities and Entangled Madness: Transferring Psychiatry to the Colonial Pacific, 1884–1964', in W. Ernst and T. Mueller, eds, *Transnational Psychiatrists: Social and Cultural Histories of Psychiatry in Comparative Perspective c.1800–2000* (Newcastle, UK: Cambridge Scholars Publishing), 24–50; Jonathan Saha, 'Madness and the Making of a Colonial Order in Burma', *Modern Asian Studies*, 2013, 47, 406–35. Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley: University of California Press, 1999); Richard Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago: University of Chicago Press, 2007); Martin Summers, "'Suitable Care of the African When Afflicted With Insanity": Race, Madness, and Social Order in Comparative Perspective', *Bulletin of the*

History of Medicine, 2010, 84, 58–91; Matthew Heaton, 'Aliens in the Asylum: Immigration and Madness in Gold Coast', *Journal of African History*, 2013, 54, 373–91.

¹¹Bronwyn Labrum, 'Looking Beyond the Asylum: Gender and the Process of Committal in Auckland, 1870–1910', *New Zealand Journal of History*, 1992, 26, 125–44; Catharine Coleborne, *Insanity, Identity and Empire: Immigrants and Institutional Confinement in Australia and New Zealand, 1873–1910* (Manchester: Manchester University Press, 2015).

¹²Australian Bureau of Statistics, *Australian Historical Population Statistics, 2008* (Canberra, ACT: Australian Bureau of Statistics), table 2.1.

¹³Frederick Manning, 'Insanity in Australian Aborigines, with a Brief Analysis of Thirty-two Cases,' in *Intercolonial Medical Congress of Australasia*, ed., *Transactions of the Intercolonial Medical Congress of Australasia, 2nd Session* (Melbourne, Vic: Stillwell and Co, 1889), 857–60; John Bostock, 'Insanity in the Australian Aboriginal and Its Bearing on the Evolution of Mental Disease', *Medical Journal of Australia*, 1924, 2, 459–64; John Cawte, *Medicine is the Law: Studies in Psychiatric Anthropology of Australian Tribal Societies* (Hawaii, USA: University Press of Hawaii, 1974); Ernest Hunter, 'Double Talk: Changing and Conflicting Constructions of Indigenous Mental Health', *Australian and New Zealand Journal of Psychiatry*, 1997, 31, 820–7; Edmund McMahon, 'Psychiatry at the Frontier: Surveying Aboriginal Mental Health in the Era of Assimilation', *Health and History*, 2007, 9, 22–47.

contemporary Australian data on Aboriginal people's use of mental health services is poor, it is not surprising to find that analysis of the period before the 1960s is also fragmentary, even though many other historical aspects of Aboriginal people's lives have been studied closely. Major works on the history of mental illness in Australia barely mention Aboriginal people, let alone provide any analysis of their situation.¹⁴ Most of these studies focus on Australia's urban settlements and thus exclude Aboriginal people in rural and remote areas, unless they were transported to urban asylums. Conversely, historical studies of Aboriginal life in Western Australia mostly omit any mention of mental health issues or incarceration in asylums.¹⁵ However, Martyr has examined some primary source records for nineteenth-century Aboriginal lunacy admissions in Western Australia, and found that these largely matched the profile of non-Aboriginal lunacy admissions in the same period: labouring class males, vagrants, those who were elderly and physically sick and females suffering from lack of family support.¹⁶ One significant difference was that alcohol was not a factor in most Aboriginal nineteenth-century admissions, whereas alcohol abuse was a relatively common cause of non-Aboriginal mental hospital admissions in the same period.

This paper will examine twentieth-century Aboriginal admissions to Western Australian mental hospitals, using restricted records, to create an initial historical statistical profile of Aboriginal mental health service use. We will also use newspaper reports, evidence from government inquiries and extracts from an oral history project on the history of Claremont Hospital to provide insights into the lived experiences of Aboriginal people in mental hospitals in this period. The original voices of the patients have been almost completely lost, but there are oral and written accounts from as early as 1911 through to the late 1960s which capture staff descriptions and impressions of these admissions of Aboriginal people. These documents and oral histories sometimes use terms to describe Aboriginal people which are considered offensive today.

Finding Aboriginal People in Mental Health Records

This topic remains largely unexplored by historians for three reasons: it is difficult to access many Australian mental health records, it is difficult to find Aboriginal people in those records, and it is difficult to interpret the data meaningfully by comparing it to other historical indicators of Aboriginal health and well-being. In Australia, mental health services are provided separately by the six State governments, which creates six different mental health systems with unique histories and record sets. Each State has its own collection of historical mental health records, protected by privacy and record-keeping legislation which can restrict access for up to 100 years. Even data in the public

¹⁴John Bostock, *The Dawn of Australian Psychiatry* (Sydney: Australasian Medical Association, 1968); Stephen Garton, *Medicine and Madness: A Social History of Insanity in New South Wales 1880–1940* (Sydney: University of New South Wales Press, 1988); Catharine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860–1914* (London: Palgrave Macmillan, 2010); but see also Bain Attwood, 'Tarra Bobby, a Brataualung Man', *Aboriginal History*, 1987, 11, 41–57.

¹⁵Anna Haebich, *For Their Own Good: Aborigines and Government in the South West of Western Australia, 1900–1940* (Perth: University of Western Australia Press, 1992); Mary Ann Jebb, *Blood, Sweat and Welfare: A History of White Bosses and Aboriginal Pastoral Workers* (Crawley: University of Western Australia Press, 2002).

¹⁶Martyr, "'Behaving Wildly'", 321.

domain—such as each State’s annual mental health reports, which were highly idiosyncratic—does not always identify Aboriginal people clearly or consistently in the twentieth century.

This State-based idiosyncrasy also extends to reporting on other historical indicators of health and well-being for Aboriginal Australians. Historically, each State or Territory in Australia had a different Aboriginal population, itself made up of diverse language groups, and defined, distributed and managed differently by State authorities. Aboriginal Australians were not counted in the Australian national census until after 1967, but individual States estimated their Aboriginal populations from time to time.¹⁷ There is considerable variation between the States in their historical treatment of Aboriginal people and the quality of their record-keeping, which means that there is little consistent and reliable national data on Aboriginal health, income, workforce participation and other indicators of well-being before the 1970s. One exception is imprisonment: there is considerable data and analysis available relating to Aboriginal people in the criminal justice system.¹⁸

To complicate matters further, Western Australia’s historical annual mental health reports are skeletal compared to those produced by other States, which means that primary sources have to be accessed directly. While most individual case notes have been destroyed, the handwritten admissions registers for the principal public mental hospitals have survived, and are held by the State Records Office of Western Australia under 100 year restriction. They have been accessed for this research with the permission of the Western Australian Department of Health, as part of a larger project with ethics approval from the North Metropolitan Health Service Mental Health Human Research Ethics Committee, and with restrictions on the use of name-identified patient data. The oral history interviews were recorded from 2009 to 2010 as part of the same project, and all oral history participants signed release forms allowing the publication of information from their interview transcripts, and have chosen a pseudonym if they wished.

Western Australia’s small population and limited number of public mental health institutions make it possible to capture a manageable dataset of admissions from 1903 to 1966. In 1903 Claremont Mental Hospital (1903–1972), the largest standalone psychiatric institution in Western Australia, began receiving admissions, and in 1966 computerised mental health data collection began in Western Australia, which marks the end of the handwritten data series.¹⁹ At its peak, Claremont accommodated close to 1,700 long-term and largely intractable patients. Heathcote (1929–1994), with some 90 beds, was originally built as a reception home to reduce admissions to Claremont. Claremont

¹⁷Gordon Briscoe, *Counting, Health and Identity: A History of Aboriginal Health and Demography in Western Australia and Queensland, 1900–1940* (Canberra, ACT: Australian Institute of Aboriginal and Torres Strait Islander Studies, 2003); Tiffany Shellam, “‘Our Natives’ and “‘Wild Blacks’”: Enumeration as a Statistical Dimension of Sovereignty in Colonial Western Australia”, *Journal of Colonialism and Colonial History*, 2012, 13, 1–19.

¹⁸This field is large and multidisciplinary, but see for example Mark Finnane, ‘A Politics of Prosecution: The Conviction of Wonnerwerry and the Exoneration of Jerry Durack in Western Australia 1898’, *Law in*

Context, 2015, 33, 60–73; Mark Finnane and Jonathan Richards, ‘Aboriginal Violence and State Response: Histories, Policies and Legacies in Queensland 1860–1940’, *Australian and New Zealand Journal of Criminology*, 2010, 43, 238–62. The findings from the Australian government’s Royal Commission into Aboriginal Deaths in Custody (1987–1991) should also be read in this context.

¹⁹The computerised dataset from 1966 is maintained by the WA Department of Health’s Mental Health Information System (MHIS), which has a different protocol for access.

operated under Western Australia's Lunacy Acts (1903–1965), where admissions had to be certified as insane, whereas Heathcote operated under the Mental Treatment Acts (1917–1965), which allowed for up to six months' care before either discharge or certification.

Both Claremont and Heathcote in this period accepted admissions of any age, including young children.²⁰ There were almost no private mental hospitals in Western Australia in this period, and no separate facilities for older adults with mental health problems or people with developmental disabilities. There were also no specialist Aboriginal health facilities in Western Australia, except 'lock' hospitals in remote areas for the isolation and treatment of sexually transmitted diseases and leprosy, and no special provisions were made for Aboriginal admissions under the Lunacy or Mental Treatment Acts.²¹

Staff recorded information required by legislation in the admissions registers, but this did not include ethnicity, although the registers had a column for recording 'Nativity'. This was sometimes used by staff to identify ethnicity, such as recording 'Singapore (British)' to indicate a white person born in Singapore. This is where most Aboriginal admissions were identified as such. Other columns where this information might be recorded were as follows: 'Name', when the first name only was used, accompanied by the word 'Abo', 'Aboriginal', or 'half-caste' in brackets. If the admission had both an Aboriginal name and an English name, the symbol '@' (alias) would be used; 'Occupation', terms such as 'Native' or 'Abo' were sometimes used to describe the admission's occupation; 'Residence', if the admission's residence was a mission, station or 'native camp', this may not always indicate Aboriginal identity, but it was used to confirm an Aboriginal identity tentatively identified in other notations or comments.

As a series of government inquiries and Royal Commissions showed, the Claremont and Heathcote registers were often unreliable, and data was not recorded consistently for all admissions.²² This includes ethnicity, even for the one individual: in some cases a person's Aboriginal identity was recorded in the Heathcote register but not the Claremont register, or an Aboriginal identity was only recorded after the person had died. This lack of consistency makes it difficult to track individuals through the system, and also makes it difficult to produce an accurate count of the number of Aboriginal people in the mental health system. For this reason, a count of admissions has been used, rather than a count of persons. The data has been organised into admission rates,

²⁰Other government-run mental hospitals in Western Australia included Lemnos (1926–1990) for war veterans, Whitby Falls (1897–2005) for long-term low-acuity male admissions, and Green Place (1918–1979) for long-term low-acuity female admissions. These three hospitals accounted for only around 100 of all Western Australia's public mental health admissions in any given year, as the overwhelming majority were admitted to Heathcote and/or Claremont.

²¹Mary Ann Jebb, 'The Lock Hospitals Experiment: Europeans, Aborigines and Venereal Disease', *Studies in Western Australian History*, 1984, 8, 68–87; Karl Eckermann, 'Lock Hospitals, Prisons and Indigenous People, Queensland and Western Australia, 1906–98', in P. Read, ed., *Settlement:*

A History of Australian Indigenous Housing (Canberra: Aboriginal Studies Press, 2000), 209–20; Philippa Martyr, 'Equal Under the Law? Indigenous People and the Lunacy Acts in Western Australia to 1920', *University of Western Australia Law Review*, 2011, 35, 317–39.

²²Western Australia, *Report of the Select Committee of the Legislative Assembly on the Claremont Hospital for the Insane* (Perth: Government Printer, 1919); *Report and Appendices of the Royal Commission in Lunacy* (Perth: Government Printer, 1922); *Report of the Royal Commission to Inquire into the Heathcote Mental Reception Home and the Administration of Mental Hospitals Generally* (Perth: Government Printer, 1938).

demographics (age, religion, marital status, occupation, place of origin/residence), diagnoses, and outcomes.

Creating a Statistical Profile of Aboriginal Admissions, 1903–1966

Between 1902 and 1966, we found 164 admissions (98 males and 66 females) of individuals identified as Aboriginal to Claremont and Heathcote, out of a total of just over 37,000 admissions. At least 17 of these Aboriginal admissions (12 male, 5 female) were individuals who were admitted more than once. Estimates of the Aboriginal population in Western Australia range from as high as 13 per cent of all persons in 1901 to as low as 2.9 per cent in 1966, but in this period they make up only 0.44 per cent of all admissions to mental hospitals.²³ Martyr found that the Aboriginal percentage of the resident asylum population between 1898 and 1914 ranged between 1 per cent and 1.7 per cent of all persons in mental hospitals in any given year, which is again disproportionately low.²⁴

By using the estimated Aboriginal population of Western Australia across this period, we found an overall average admission rate of 1.17 per 1,000 people, compared to an overall average non-Aboriginal admission rate of 8.57 per 1,000 people in the same period.²⁵ There were around two identified Aboriginal admissions to public mental hospitals each year in Western Australia, but between 1958 and 1966 the numbers of identifiable Aboriginal admissions dropped dramatically, which means that either there was a genuine reduction in Aboriginal admissions, or the staff stopped identifying admissions as Aboriginal in the records.

The age of Aboriginal admissions was recorded reasonably consistently, with 78 males (79.6 per cent) and 57 females (86.3 per cent) having an age recorded on admission. However, age was sometimes estimated and sometimes later corrected. For example, one Aboriginal patient admitted in 1926 was estimated to be 60 on admission, but only 54 at death a few months later. In some cases extremes of age were estimated, such as '100+' years. The overall reliable age range was 2–75 years of age, with a median age at admission of 31 years for males and 25 years for females (Figure 1).

Religion was the least well-recorded element of the Aboriginal admissions data: only 28 male admissions and 22 female admissions had any data recorded. The majority of those with an identified religion were Roman Catholic (13 per cent overall). The high numbers of admissions with no data recorded may be because staff understood 'religion' as meaning variations of Christianity, and assumed that in its absence the Aboriginal person had no religious beliefs. Twelve admissions had their religious affiliation recorded as 'native', 'pagan', or 'atheist'. There is no reliable data available on the religious affiliations

²³Australian Bureau of Statistics, *Australian Historical Population Statistics*, 2008.

²⁴Martyr, 'Equal Under the Law?', 325.

²⁵Australian Bureau of Statistics, 'Statistics on the Indigenous Peoples of Australia', *Year Book Australia, 1994* (Canberra, ACT: Australian Bureau of Statistics, 1994); Australian Bureau of Statistics, *Australian Historical Population Statistics*, 2008. See also Helen Hughes, 'Who Are Indigenous Australians?', *Quadrant*, 2008, 52, 26–32; Australian

Law Reform Commission, *Essentially Yours: The Protection of Human Genetic Information in Australia*, ALRC Report 96 (Canberra, ACT: Commonwealth of Australia, 2003). Calculated using Aboriginal population census estimates for the national census years 1911, 1921, 1933, 1947, 1954, 1961 and 1966, and the total census population figures for the same years only. But see also Briscoe, *Counting Health and Identity*.

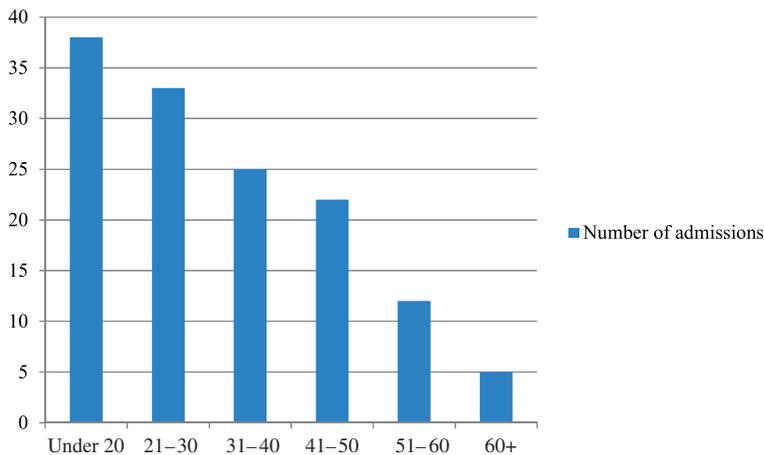


Figure 1. Age distribution of Aboriginal admissions, 1903–1966

of Western Australia's Aboriginal people for this period, so it is not possible to determine how representative this group is of Aboriginal people in general at this time.

Seventy male admissions (71 per cent) and 55 female admissions (83 per cent) had their marital status recorded, and the majority of these were single (61.1 per cent overall). Marital status could be recorded differently from one admission to another. Unusually, there were roughly the same numbers of married male and female admissions over this period, whereas non-Aboriginal admissions to these hospitals were skewed heavily towards unmarried males, especially in the earlier decades of the twentieth century.²⁶

Like religion, occupation was either not consistently recorded, was assumed to be absent, or was genuinely absent: only 57 male admissions (58 per cent) and 39 female admissions (59 per cent) had an occupation recorded (Table 1). Of the 71 admissions who had no occupation recorded, 27 gave their address as missions, stations or government institutions. Historically, Aboriginal people have experienced higher rates of welfare dependency and lower rates of workforce participation in Australia than the rest of the population, although statistical evidence from before 1970 is negligible.²⁷ If the figures genuinely represent workforce participation for this group, then only 30 per cent of the Aboriginal admissions over this period were in the paid workforce.

Of those with an occupation recorded, the single largest group ($n = 30$) were employed in station or farming work (almost 18 per cent of all admissions, and 31 per cent

²⁶Philippa Martyr, 'Having a Clean-Up: Deporting Migrant Lunatics from Western Australia, 1924–1939', *History Compass*, 2011, 9, 171–99.

²⁷Rae Norris, 'Australian Indigenous Employment Disadvantage: What, Why and Where to from Here?', *Journal of Economic and Social Policy*, 2001, 5, 1–22. The 1966 census estimated that 21,649 Aboriginal people out of a total population of

80,207 were in the workforce (26.9%). Australian Bureau of Statistics, *Year Book Australia, 1970* (Canberra, ACT: Australian Bureau of Statistics, 1970), 141. See also Robert Castle and Jim Hagan, 'Settlers and the State: The Creation of an Aboriginal Workforce in Australia', *Aboriginal History*, 1998, 22, 24–35.

Table 1. Most common type of occupation by sex, Aboriginal admissions, 1908–1965

	Males	Females	Total
Domestic/home duties	0	29	29
Labourer	20	0	20
Station/farming work	26	4	30
All other occupations	10	4	14
No data	42	29	71
Total	98	66	164

of those with an identified occupation). There is data available for the rates of Aboriginal employment in agricultural and pastoral industries in Western Australia for most years from 1903 to 1937: on average, 14.6 per cent of the estimated Aboriginal population in Western Australia worked in these industries over this period, which makes this group of admissions reasonably representative.²⁸

We also collected data on place of origin and residence. Aboriginal Australians have a traditionally close relationship with ‘country’: their place of origin which is home to sites of profound spiritual meaning for that person and their extended family and language group. Ability to reconnect with country is seen as an important part of an Aboriginal person’s traditional emotional well-being.²⁹ In this context, removal from country—such as being taken from a remote area by police constables to a mental hospital in a city some 2,500 kilometres away—would contribute to poorer mental health outcomes for an Aboriginal person who was connected to those traditions.

Place of origin or residence data was recorded for 82 male admissions (83 per cent) and 50 female admissions (75 per cent). In the original dataset, this information could be a town, station, mission or other location, and where possible these have been identified and matched to Western Australian regions (Table 2). The majority of Aboriginal admissions with an identified place of origin or residence lived in towns outside the metropolitan area, with the largest group from the furthest away—the far northern Kimberley and Pilbara regions (Table 3). There is little specific data available on the historical population distribution of Aboriginal people in Western Australia, so it is difficult to say how representative this is of Aboriginal Western Australians generally in this period.³⁰

Diagnoses were recorded consistently: 90 male admissions (92 per cent) and 64 female admissions (96 per cent) had a diagnosis recorded. The diagnoses are almost all pre-ICD/

²⁸Based on data published in the Statistical Register of Western Australia for these years, and using the ABS minimum estimates of the Aboriginal population in Western Australia (census years only).

²⁹Meryl Pearce *et al.*, ‘Cut From “Country”’: The Impact of Climate Change on the Mental Health of Aboriginal Pastoralists’, *Australasian Journal of Regional Studies*, 2015, 21, 50–79; Pat Dudgeon *et al.*, ‘Aboriginal Social, Cultural and Historical Contexts’, in P. Dudgeon, H. Milroy and R. Walker, eds, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and*

Practice (Canberra, ACT: Department of Health and Ageing, 2014), 3–24.

³⁰However, the Australian Bureau of Statistics estimated in 2006 that about 31% of the Aboriginal population was living in ‘major cities’ (as defined by the Australian Bureau of Statistics/Australian Standard Geographical Classification) and 45% in ‘regional Australia’, with the remaining 24% in remote areas. Australian Bureau of Statistics, *Population Distribution, Aboriginal and Torres Strait Islander Australians* (Canberra, ACT: Australian Bureau of Statistics, 2006), 6.

Table 2. Place of origin and/or residence by current WA health region, Aboriginal admissions, 1908–1965

WA region	Males	Females	Total
Kimberley	20	10	30
Pilbara	17	10	27
Wheatbelt	10	15	25
Midwest	18	4	22
Goldfields-Esperance	8	6	14
Perth	4	1	5
All other areas	5	4	9
Unidentifiable	10	9	19
No data	6	7	13
Total	98	66	164

Table 3. Place of origin and/or residence by type, Aboriginal admissions, 1908–1965

	Males	Females	Total
Towns (including metropolitan area)	45	26	71
Cattle/farming stations	19	7	26
Government institutions	8	14	22
Aboriginal camps/traditional lifestyle	9	5	14
Religious missions	8	6	14
All other sites/no fixed abode	3	1	4
No data	6	7	13
Total	98	66	164

DSM, and have been divided here into those which appear to have been of physical origin, and those which are closer to a modern understanding of a psychiatric disorder (Table 4), based on the primary diagnosis only. Of all Aboriginal admissions in this period, 35.9 per cent had a primary diagnosis of a physical or organic disorder, while 57.9 per cent were diagnosed with what would be understood today as psychiatric disorders. Because these diagnoses were developed without any clear criteria, and because all the case notes have been destroyed and access to individual admissions papers is restricted, it is impossible to validate these diagnoses, or to describe in any detail the symptoms and behaviours which may have been exhibited by the individuals concerned.

This matches the pattern of all admissions to Claremont and Heathcote between 1903 and 1965, where a review of diagnoses in the annual reports indicates that approximately a third of all admissions were diagnosed with primarily physical disorders, including epileptic disorders, developmental disabilities, neuropsychiatric syndromes such as Parkinson's and Huntingdon's diseases, acquired brain injuries, and infection-related neurological conditions.³¹ The majority of the Aboriginal psychiatric diagnoses are psychosis-related, with the exception of the eight admissions with melancholia. Females

³¹Western Australia, *Report of the Inspector General of the Insane* (Perth, WA: Government Printer), 1903–1965, using all reported data on diagnoses of admis-

sions to hospitals under the Lunacy Act and the Mental Treatment Act.

Table 4. Physical and psychiatric diagnoses, Aboriginal admissions, 1908–1965

Diagnosis	Males	Females	Total
<i>Physical/organic disorders</i>			
'Mental deficiency' (all forms)	10	8	18
Neurosyphilis (all forms)	8	2	10
Epileptic disorders	5	4	9
Psychiatric conditions of old age	7	0	7
Acquired head injuries	2	2	4
Puerperal conditions	0	1	1
Subtotal	32	17	59
<i>Psychiatric disorders</i>			
Mania	22	8	30
Schizophrenia	9	15	24
Dementia praecox	4	12	16
Melancholias	7	1	8
Confusional/delusional insanity	5	2	7
Manic depressive psychosis	1	3	4
Paraphrenia	3	1	4
'Dementia', non-senile	2	0	2
Subtotal	53	42	95
No data	8	2	10
Unclear/other	5	5	10
Total	98	66	164

were more likely to be admitted with schizophrenia-type diagnoses (schizophrenia, dementia praecox and paraphrenia), while males were more likely to be admitted with mania, neurosyphilis and psychiatric conditions of old age.

Outcomes were recorded for almost all patients: 85 males (97 per cent) and 51 females (89 per cent) (Table 5). The most common outcome for Aboriginal admissions was death in Claremont: around half of all Aboriginal admissions eventually died there. There was enough data to calculate the length of stay for 91 male and 57 female admissions, which showed that the majority of Aboriginal admissions left hospital, whether by death or discharge, within a year of admission. Few Aboriginal admissions became long-term patients at Claremont: only 15 admissions with a recorded outcome spent more than ten years in Claremont, of whom 13 eventually died there.

There is some documentary evidence that Aboriginal admissions were classed as 'paupers', and that if they died in Claremont, their remains would be buried at government expense in nearby Karrakatta Cemetery. For example, in 1918 two Aboriginal admissions, one male and one female, died within a month of each other in Claremont. They were both buried at Karrakatta at a total cost of £1 5s, and their burial was paid for by the Western Australian government's Department of Aborigines and Fisheries.³² It is very unlikely that an Aboriginal person's remains in this period would have been returned to country from a public institution. Place of death is highly significant for most indigenous cultures, and death away from country, particularly in a hospital, was and is a frightening

³²Admission of 'Konkey' alias 'Charlie' of Albany to Claremont Hospital for Insane, AU WA S1644-

cons652 1918/1038, State Records Office of Western Australia, Perth, Western Australia.

Table 5. Outcomes for Aboriginal admissions, 1908–1965

	Males	Females	Total	% of all Aboriginal admissions
Died	59	28	87	53.0%
Discharged	9	14	23	14.0%
Transferred to Claremont	11	9	20	12.2%
On trial leave	10	5	15	9.1%
Transferred (unspecified)	2	2	4	2.4%
Not insane	1	0	1	0.6%
No data	6	8	14	8.5%
Total	98	66	164	100.0%

and lonely prospect for an Aboriginal person and their family and community.³³ The knowledge that so few Aboriginal people would ever return from an admission to Claremont may well have kept many Aboriginal people from seeking any help for a mentally ill relative, and may help to account for the very low numbers of admissions across this period.

Aboriginal people admitted to mental hospitals died from chronic physical illnesses, including tuberculosis and cardiovascular disorders, as well as terminal conditions such as bronchitis or pneumonia probably contracted while in hospital (Table 6). This high rate of chronic physical illness also helps to account for the fact that of all Aboriginal inpatient deaths, 36.7 per cent (22 males and 10 females) took place within a year of their admission.³⁴ There was a median length of stay of 1.6 years until death for males (1 day–46.4 years) and 2.1 years for females (15 days–23.8 years). This is consistent with all admissions: Claremont Hospital regularly admitted people who were chronically and seriously physically unwell, and data extracted from Claremont Hospital's admissions registers at five-year intervals from 1910 to 1950 shows that of all deaths in Claremont, 33.8 per cent took place within a year of the person's admission.

Females were overall more likely to be discharged than males, and the 19 admissions to Heathcote who did not progress to Claremont had better outcomes: 13 (68 per cent) were discharged on trial leave, and four were discharged outright. All Aboriginal patients discharged from Heathcote were discharged within 12 months, and most were discharged in under 6 months, which was standard procedure under the Mental Treatment Acts. This is also consistent with Heathcote's role as a reception home for less seriously unwell patients, and its operational policy of sending more seriously unwell patients to Claremont after initial assessment.

³³Pam McGrath, 'I Don't Want To Be In That Big City; This Is My Country Here': Research Findings on Aboriginal Peoples' Preference to Die at Home', *Australian Journal of Rural Health*, 2007, 15, 264–8.

³⁴The poor overall physical health of Aboriginal people, notably those who had experienced white contact, was frequently commented on by white observers in the nineteenth century, and was formally investigated by medical researchers from at least the late 1920s. Peter Dowling, "'A Great Deal of Sickness":

Introduced Diseases Among the Aboriginal People of Colonial Southeast Australia 1788–1900', PhD, 1997, Australian National University, provides a good introductory overview to Australian historical accounts of Aboriginal ill health, as does Ernest Hunter, *Aboriginal Health and History: Power and Prejudice in Remote Australia* (Melbourne: Cambridge University Press, 1993). See also Briscoe, *Counting, Health and Identity*.

Table 6. Causes of death, Aboriginal admissions, 1908–1965

	Males	Females	Total
Bronchitis/pneumonia	14	6	20
Cardiovascular diseases	14	5	19
Tuberculosis	9	6	15
Sexually transmitted diseases	6	2	8
Gastric diseases	4	0	4
Mania	2	2	4
Epilepsy	2	0	2
All other causes	3	3	6
Unknown	5	4	9
Totals	59	28	87

So what does this cohort look like overall? They are a small group, relatively young, and very unwell. Over the twentieth century, Claremont and Heathcote gradually accepted larger and larger numbers of older adults with mental health problems associated with age, which meant that the median age of all admissions jumped dramatically from 37 years of age for both males and females in 1933 to 48 years for males and 56 years for females in 1953. The Aboriginal admissions' comparative youth may be a reflection of lower life expectancy for Aboriginal people in this period.³⁵ No figures are available for Claremont and Heathcote on the numbers of admissions from rural and remote areas overall, but the place of origin of these Aboriginal admissions was consistently outside of the metropolitan area, and in the majority of cases from the far north, at least 1,000 kilometres away.

Discussions of Aboriginal mental illness also cut across contemporaneous debates about the perceived relationship between substance abuse (particularly alcohol) and mental illness, which was seen as a common problem for both the Aboriginal and non-Aboriginal population in twentieth century Australia.³⁶ Various forms of legal prohibition of alcohol purchase and consumption were applied to Aboriginal communities until the 1960s in Australia, which may help to explain the very low rates of recorded substance abuse—only 3 of the 164 admissions, or less than 2 per cent. By contrast, from 1903 to 1910, 6.4 per cent of all admissions to Claremont were for substance abuse, although by 1930 this had fallen to 2.9 per cent.³⁷

There are also some consistencies with all admissions in the same period: a higher proportion of males to females, high rates of admissions in poor physical health, and a high death rate within a year of admission. Western Australia's small population and lack of specialised health facilities in this period meant that many individuals with complex

³⁵The first reliable national attempt to calculate Aboriginal life expectancy seems to have taken place after the 1996 census. Australian Bureau of Statistics, *Discussion Paper: Assessment of Methods for Developing Life Tables for Aboriginal and Torres Strait Islander Australians* (Canberra, ACT: Australian Bureau of Statistics, 2006). Currently Aboriginal life expectancy in Australia is approximately 10 years less than that of non-Aboriginal Australians.

³⁶Maggie Brady, 'Equality and Difference: Persisting Historical Themes in Health and Alcohol Policies Affecting Indigenous Australians', *Journal of Epidemiology and Community Health*, 2007, 61, 759–63.

³⁷Western Australia, *Report of the Inspector General of the Insane, 1903–1910*, using all reported data on diagnoses of admissions to hospitals under the Lunacy Act and the Mental Treatment Act.

physical disorders, developmental disabilities and co-morbid illnesses were sent to public mental hospitals for long-term accommodation and management, and around one-third of all Aboriginal mental health admissions fell into this category. The high proportion of Aboriginal people with mental health problems of apparently physical origin helps to highlight the poor overall health of this group of admissions.³⁸

The acuity of the diagnoses is noteworthy: most of these patients had to be brought long distances to be admitted to Heathcote or Claremont, and this was unlikely to take place unless their illness was too serious to be treated or managed in the local community any longer. The high death rate is almost certainly linked to the acuity of the diagnoses and the high rate of admissions with serious physical disorders, as well as other factors such as separation from traditional country and local communities. The extremely low numbers of identified Aboriginal admissions before 1966, the seriousness of their diagnoses, and the high rate of obvious physical co-morbidities, seem to confirm Martyr's hypothesis that the mental health system was the last port of call for Aboriginal people with serious mental illness in Western Australia before the 1970s.³⁹

This low number of Aboriginal admissions may also relate to institutionalised racism. General hospital services were not always accessible to Aboriginal people, and/or discriminated against them directly or indirectly in their admission policies and practices. Aboriginal people with severe mental illness may also have been more likely to be dealt with as a criminal justice issue, or within missions or other institutional settings. These factors, along with fear at the prospect of dying away from country, and other negative experiences of involvement with State government services, may have kept Aboriginal people from seeking help for any other than the most serious and disruptive mental disorders. The high cost of transporting Aboriginal people from remote areas to the city also made removal to Claremont an unattractive solution for the State and its agencies. Aboriginal people appear to have been in a double bind: unwilling or unable to seek help from public mental health services that were equally unwilling or unable to assist them.

Perceptions of Aboriginal People in Western Australian Mental Hospitals, 1911–1966

So, with such low numbers of Aboriginal admissions to mental hospitals during this period, and no way of capturing what they may have said, done, thought or felt, what can we know of their lived experience? To begin to reconstruct this, we have used newspaper reporting of mental illness among Aboriginal people in Western Australia, evidence given to government inquiries into the mental hospital system, and oral history collection. These sources—which are all from non-Aboriginal observers and participants—all reflect different concerns about and attitudes to Aboriginal people with mental illness.

³⁸Lorelle Barry and Catharine Coleborne, 'Insanity and Ethnicity in New Zealand: Maori Encounters With the Auckland Mental Hospital, 1860–1900', *History of Psychiatry*, 2011, 22, 285–301.

³⁹Martyr, 'Equal Under the Law?', 338. Recent research has confirmed that for many Aboriginal families, psychiatric hospital admission remains a last resort, as hospitals are seen as unpleasant and

frightening, and places which do not incorporate or understand the role of Aboriginal families in caring. Michael Wright, 'Reframing Aboriginal Family Caregiving', in P. Dudgeon, H. Milroy and R. Walker, eds, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Canberra, ACT: Department of Health and Ageing, 2014), 243–56.

There are comparatively few references to Aboriginal people with mental illnesses in newspaper reporting in Australia at this time, and those which were reported in Western Australia tended to be of incidents which took place in other States. The 1903 case of Norn (alias Noru, Korn, and Johnson), an Aboriginal man living near Esperance on the State's southern coast, who was arrested for murdering his wife Jessie, attracted considerable attention both for the violence of the crime and the eventual decision to commit him to Fremantle Lunatic Asylum.⁴⁰ In 1937, when a naked man escaped from the Bloomfield mental hospital in Orange, New South Wales, and outran a horseman who pursued him, the story was reported in Perth's *Daily News*: 'The man, who is said to be of aboriginal [sic] blood, is described as of middle age and powerfully built. The hospital authorities state that he is harmless.'⁴¹ In 1945, the Perth *Mirror* also reported a case in neighbouring South Australia where a female Aboriginal patient in a mental hospital kicked a female non-Aboriginal patient to death.⁴²

Fear of violence by 'coloured lunatics' could be further complicated by fears of sexual contact. In 1929 the Perth *Truth* reported that a white female patient gave birth to a child fathered by an Aboriginal patient at Bloomfield Hospital in Orange.⁴³ This story revealed the terrifying eugenic prospects for a child with inherited lunacy and Aboriginality:⁴⁴

The father of the child is a black man, and although he had a streak of white blood in his veins, the black colour predominates so greatly that he could be mistaken for a full aborigine. The thought of a white woman bearing a child to a black man is nauseating in the extreme. But the thought of a coloured lunatic becoming the father of a mad white woman's child is so ugly that it scarcely can be contemplated without a shudder.⁴⁵

In 1911, the Perth *Sunday Times* published a series of complaints about Claremont Hospital, including a description of how an Aboriginal man had died of tuberculosis in the hospital ward at Claremont after probable cross-infection.⁴⁶ The ethnic mix of Claremont Hospital was sometimes mentioned in newspaper reporting, usually in unflattering terms. A visitor to Claremont in 1920 was taken on a tour of the wards, including the male hospital ward, which housed 'Chinamen [sic] (of whom there is a considerable sprinkling over the whole asylum), aborigines [sic], Greeks and what not . . . among these

⁴⁰*Ibid.*, 329.

⁴¹'Naked Lunatic Won Race with Horseman', *Daily News*, 2 February 1937.

⁴²'Abo Lunatic Kicks Woman to Death', *Mirror*, 16 June 1945.

⁴³'Baby Born in Asylum of Lunatic Parents—Black Madman Is Father of White Woman's Child', *Truth*, 1 December 1929.

⁴⁴A full discussion of white Australian eugenic fears of Aboriginality and miscegenation is outside the scope of this paper, but key references include M. Crotty, J. Germov and G. Rodwell, eds, *A Race for a Place: Eugenics, Darwinism and Social Thought and Practice in Australia* (Callaghan, NSW: Faculty of Arts and Social Science, University of Newcastle, 2000) and Russell McGregor, *Imagined Destinies: Aboriginal*

Australians and the Doomed Race Theory, 1880–1939 (Carlton, Victoria: Melbourne University Press, 1997). See also Cindy Solonec, 'Proper Mixed-Up: Miscegenation among Aboriginal Australians', *Australian Aboriginal Studies*, 2013, 76–85 and Liz Conor, '"Born and Nurtured in Darkest Ignorance": White Imaginings of Aboriginal Maternity', in L. Boucher, J. Carey and K. Ellinghaus, eds, *Historicising Whiteness: Transnational Perspectives on the Construction of an Identity* (Melbourne, Vic.: RMIT Publishing / School of Historical Studies, University of Melbourne, 2007), 171–8.

⁴⁵'Baby Born in Asylum of Lunatic Parents'.

⁴⁶'The Claremont Asylum', *Sunday Times*, 5 March 5, 1911.

unfortunates repulsive in their utter degradation but for the saving thought of their terrible affliction and right to the sympathy of their more fortunate fellow-men.⁴⁷

Were Aboriginal patients in mental hospitals treated differently because of their ethnicity? In 1919 a parliamentary select committee heard evidence about the poor conditions at Claremont Hospital, including the treatment of an Aboriginal man, Neebajong, who had been sent to Claremont's ward M3 (the hospital ward) where Alexander Grimaldi had nursed him. Grimaldi testified to the select committee:

That man lay for the best part of three days writhing in agony owing to the retention of the urine and, to my way of thinking, and to that of every other attendant, the doctor should have done something in the way of using a catheter to relieve him. He lay there for three days until he died. That seemed an outstanding case. Ordinarily if a patient is suffering from a retention of urine, it is taken from him, but in this case it seemed that Neejabong was a blackfellow and they did not take much notice of him.⁴⁸

The 1938 Royal Commission into alleged mismanagement at Heathcote also revealed discrimination against Aboriginal admissions. Attendant Edward Plush was asked whether, on visiting days, any distinction was shown between the patients. He answered, 'Yes, sometimes we might have an aboriginal [sic] about, and he is pushed into the bathroom or lavatory, anywhere out of sight, where the visitors will not see him.'⁴⁹ When asked if any other patients were treated in this way, Plush identified a hunchbacked patient who was also hidden on visiting days, by order of the matron.⁵⁰ When asked if the 'coloured man [was] violent or dangerous', Plush replied, 'One coloured man was violent, but he did not see any visitors. The others were quite normal in their actions and well behaved.'⁵¹

Oral histories from former staff at Claremont and Heathcote, who worked from the 1940s to the 1960s, show common themes when asked to describe their experience of Aboriginal patients. Most concur that Aboriginal admissions were very few in number. Former attendant Bill Louvel worked at Claremont from 1940 to 1975: 'There weren't a great lot, but then there aren't a great lot of Aboriginals, percentage wise, I don't know, but there was always some of them there, always in ward 2 [refractory ward], you had some. ... Every ward would have had some, maybe 2 or 3.'⁵² Former nurse Maiga Houlahan, who migrated from Latvia after the Second World War and began working at Claremont in around 1950, recollected: 'Not that many [Aboriginal patients]. But a few.

⁴⁷'The Truth about Claremont—Delusions of the Insane—the Story Concluded', *Sunday Times*, 5 December 1920.

⁴⁸Western Australia, *Report of the Select Committee*, q1106.

⁴⁹Western Australia, *Report of the Royal Commission to Inquire into the Heathcote Mental Reception Home and the Administration of Mental Hospitals Generally*, Minutes of Evidence, volume 1, 4 October 1938, 513, Psychiatric Services Library Archive, Graylands Health Campus, Mount Claremont, Western Australia.

⁵⁰*Ibid.*, 514.

⁵¹*Ibid.*, 515. In this period, there were only four Aboriginal male admissions to Heathcote, all from remote areas, three of whom were transferred to Claremont within a few months.

⁵²Bill Louvel, interview by [article co-author], 5 June 2009, Graylands History Project, North Metropolitan Health Service Mental Health, Graylands Health Campus, Mount Claremont, Western Australia (hereafter Graylands History Project).

Some were very nice, and some were working in the wards like that, and being helpful, and there's no problem at all. And some—so we didn't have any problems, it's only one that heard these voices and that.⁵³

Robert McDonald, who worked as an attendant at Claremont from 1947 to 1951 and who later worked as a police officer in rural Western Australia, provided his own explanation as to why there were so few Aboriginal admissions:

See, I don't think anyone bothered—if they were mad, they stayed mainly in the outback or camped off somewhere, and nobody was interested in them . . . there weren't a lot, but police tended to lock them up and then let them go, and they of course moved around quite a bit; they never stayed in one place too often very long. There were only reserves for them; there was no housing anywhere for Aboriginals. So—their life was always very hard.⁵⁴

The only dissenting voice was that of former attendant Stan Dixon, who worked at Claremont from 1947 to 1978, who recollected: 'Oh yeah, quite a lot of Aboriginal patients. They were in a circular door [revolving door], I think.'⁵⁵ 'Ludwig', a staff member who began working at Claremont in the early 1960s, also recalled that:

Aboriginal patients were not rare but I never heard of a voluntary Aboriginal patient. I noted that the number of urban Aboriginals [sic] was far lower than it should have been in proportion to their demographics in the city. . . . I theorise that Aboriginals [sic] simply did not enter the mental health system unless they were severely psychotic. . . . When I was a student I remarked on the extremely low number of urban Aboriginals [sic] we saw in Claremont and I can only remember two or three.⁵⁶

I asked [an Aboriginal patient] what they did with mad people in the bush and he told me they allowed them to behave as they wished unless they were violent; in that case they would confine them to the edge of the camp. If they continued to be dangerous to people they would have to drive them away or, in desperation, kill them.⁵⁷

Where did Aboriginal admissions come from? Former staff member 'Alister McEwan', who began working at Claremont in the late 1960s, recalled that, 'some of them were local, but there were quite a few very dark people, who were from remote areas'.⁵⁸ Because of this, language barriers could exist. 'Ludwig' recalled: 'We had a number of Aboriginal men from remote regions. It was interesting to me that one paranoid schizophrenic man who arrived speaking almost no English learned to read to a degree by watching TV and had his own paranoid version of world politics from the same source.'⁵⁹ But sometimes these problems were solved in unexpected ways:

⁵³Maiga Houlahan, interview by [article co-author], 23 April 2010, Graylands History Project.

⁵⁴Robert McDonald, interview by [article co-author], 27 May 2010, Graylands History Project.

⁵⁵Stan Dixon, interview by [article co-author], 1 June 2010, Graylands History Project.

⁵⁶'Ludwig', interview by [article co-author], 29 September 2008, Graylands History Project.

⁵⁷'Ludwig', interview by [article co-author], 10 September 2009, Graylands History Project.

⁵⁸'Alister McEwan', interview by [article co-author], 12 March 2009, Graylands History Project.

⁵⁹'Ludwig', interview by [article co-author], 29 September 2008, Graylands History Project.

Another Aboriginal man was one day standing next to a Yugoslav [patient] who was rattling on in his own language . . . to my astonishment, the Aboriginal man carried on the conversation in Yugoslav. Of course, I had assumed that an Aboriginal man could not possibly speak Yugoslav but he explained to me that he had worked for a few years with Yugoslav timber cutters in the Southwest and had 'picked up the lingo'. It was a good lesson to me about making such assumptions.⁶⁰

Although interactions with Aboriginal patients could be just as violent as those with other patients, staff did not recollect these as being uniquely violent simply because those involved were Aboriginal. Bill Louvel was once assaulted by an Aboriginal patient, but ascribed that to the patient's epilepsy and mental health problems, rather than his ethnicity: 'he was a decent bloke. That night he took to me, must have been one when something disturbed his brain, he took to me. But he was quite a good decent chap really. He was all right. I didn't take it out on him for doing what he did'.⁶¹ Robert McDonald also ascribed violence to mental illness, rather than ethnicity:

But there were—there was a very violent [Aboriginal] man who was housed in Ward 2 but transferred daily down to Ward 5. And there were one or two elsewhere—that fellow, he used to become violent prior to going into an epileptic fit, because he had that twilight period of confusion and hallucination. But he was the only difficult [Aboriginal] person.⁶²

Attendant Norm Harley worked at both Claremont and Heathcote from 1954 to 1963, where his encounters with Aboriginal patients were generally positive, and he was able to see the funny side of one violent incident.

There's one patient who was brought back, his family's well known, Aboriginal, but—he was all right with us, but he hated the police. And they brought him back in handcuffs something shocking; they'd given him a bit of thump up, I believe.

But they took the handcuffs off him, and when the police said 'Oh I don't like this', they said, 'You don't bring a patient in handcuffs into this hospital'.

Next moment, this patient says, 'Yes, now I'm back here I'm as mad as a rabbit; you can't do anything'—he went BANG and hit this copper fair in the jaw. And I'm taking this bloke back to the ward, he said, 'Gee that felt nice, Norm'.⁶³

A former attendant who worked at Claremont from the 1950s to the 1980s was also involved in a violent incident with an Aboriginal male patient:

Anyway it finished up with seven of us, and we had to give the patient, an Aboriginal, we had to give him a needle. And he was in a single room, and he had demolished the steel bed, and used one of the parts as a ramrod, and bashed the door in, so the staff in the ward, they apprehended him . . . and I remember, I was

⁶⁰*Ibid.*

⁶¹Bill Louvel, interview by [article co-author], 5 June 2009, Graylands History Project.

⁶²Robert McDonald, interview by [article co-author], 27 May 2010, Graylands History Project.

⁶³Norm Harley, interview by [article co-author], 20 May 2010, Graylands History Project.

given the needle and syringe and I gave it through his trousers. Didn't even bother to take his trousers down.⁶⁴

Maiga Houlahan recollected a patient in Ward Female 2:

... we had a very big Aboriginal woman, I think she had done some harm to somebody at home, or some—killed her husband or something—and she was hearing voices all the time. And it was very dangerous really; I mean you would treat her with really. But that's what happened—they didn't have other help. Only sedation.⁶⁵

However, former nurse Evelyn Grove (who first worked at Claremont from 1949 to the early 1960s) recollected nursing and working alongside Maudie Yooringun, an Aboriginal woman who was the subject of the Australian documentary film *Case 442*. Yooringun was admitted to Claremont some time in the 1940s as a young woman, and was assigned work assisting in the children's ward.

She loved going over to the children's ward to help looking after the kids. ... Her mental state was—I couldn't understand why she was there. There must have been something that happened in the early days that we didn't know about. But she was normal enough to me ... some of the ladies, they all went—got quite violent, but never, ever did I see Maudie get violent. Oh, she was a placid little person, loveable person, actually.⁶⁶

When any admissions had physical health problems, these were mostly managed on site at Claremont and Heathcote to avoid the risks associated with patient transfers. A former staff member who began working at Claremont in the late 1960s recalled that, 'There was a ward that was for tuberculosis patients, and there were a couple of Aboriginal people in there with mental illness that also had leprosy, so that was in the TB ward.'⁶⁷ Only two staff members mentioned substance abuse in relation to historical admissions of Aboriginal people: Bill Louvel believed that many admissions 'would have been caused by the alcohol, you know; the Aboriginals can't stand the alcohol',⁶⁸ while 'Ludwig' believed the opposite—that 'Aboriginal insanity was often masked by alcohol misuse—there was not much use of other drugs in the community then.'⁶⁹

However, from the 1950s it became more common to transfer physically unwell admissions to general hospitals if they needed surgical or medical care. This led to cultural conflicts in some cases, where urban white hospital staff were not used to dealing with Aboriginal people with both physical and mental health problems. Maiga Houlahan had to assist with the transfer of a female Aboriginal patient to the local specialist women's

⁶⁴Former Attendant', interview by [article co-author], 5 May 2009, Graylands History Project.

⁶⁵Maiga Houlahan, interview by [article co-author], 23 April 2010, Graylands History Project.

⁶⁶Mitch Torres, *Case 442*, film, directed by Mitch Torres (2005, Ronin Films), Extract 3. <http://aso.gov.au/titles/documentaries/case-442/> (retrieved February 2, 2016).

⁶⁷Alister McEwan', interview by Philippa Martyr, 12 March 2009, Graylands History Project.

⁶⁸Bill Louvel, interview by [article co-author], 5 June 2009, Graylands History Project.

⁶⁹Ludwig', interview by [article co-author], 29 September 2008, Graylands History Project.

hospital, King Edward Memorial Hospital, where the woman experienced treatment that upset her.

And I remember we took a—we were detailed, a male nurse, and one of the Aborigine women, very big one, we had to take her to King Edward, because they were going to tell her how to manage her life, or whatever! And of course they upset her, and she was off! Yes, of course we were not chasing her because she was too dangerous—she was the one, I mean, but this is the trouble, you know, a lot of people are not trained with Aborigines, really.⁷⁰

Houlahan also recollected that other general health specialists showed a lack of sensitivity to the needs of Aboriginal admissions:

And then one day I had to go to Royal Perth Hospital, I was sent to supervise or see an Aboriginal patient who had come in, and the specialist came up and said [to the patient], 'On no account must you leave the bed'. Can you imagine a person that's been out in the bush and never had to pee in a bed? She couldn't do it. It was stress. I got the chair and got her on when—but they sort of don't realise that you can't put them through such stress when they are already mentally—they couldn't do it in a white [European] bed like that; they'd never had a bed before. People used to ask—and that was medical staff. Top medical staff, asking people to do that.⁷¹

Alexander Grimaldi had testified to the Select Committee in 1919 that an Aboriginal man was allowed to suffer needlessly in the hospital ward because he was 'a blackfellow', and Edward Plush reported the concealment of Aboriginal patients at Heathcote in the 1930s. Yet later oral history accounts seem to indicate that attitudes by nursing staff and other patients towards Aboriginal admissions were fairly tolerant. 'Ludwig' recollected:

One of the fine things about Claremont was that the level of racial tolerance was higher than in the general community. I rarely saw racial disharmony between patients and I don't believe patients of any ethnic background were treated differently by staff, even though I know that some staff privately were rather racist.⁷²

Another former staff member who began working in the late 1960s recollected a low level of racial tension between the patients: 'I think a lot of them were in their own worlds, you know. In terms of that, I never saw any fights that were racially motivated.'⁷³ Both Plush and Grimaldi were reporting on an earlier era, but they were also both describing behaviours by senior hospital staff—medical staff and management—rather than the attitudes and behaviours of nursing staff and other patients. This hints that racist attitudes may have been more common at the higher levels, in mental health service administration, rather than at the patient level.

⁷⁰Maiga Houlahan, interview by [article co-author], 23 April 2010, Graylands History Project.

⁷¹Maiga Houlahan, interview by [article co-author], 23 April 2010, Graylands History Project.

⁷²'Ludwig', interview by [article co-author], 29 September 2008, Graylands History Project.

⁷³'Alister McEwan', interview by [article co-author], 12 March 2009, Graylands History Project.

To an extent, Aboriginal traditional beliefs and healing practices were also respected by the staff. Norm Harley recollected an instance in the 1960s where an Aboriginal female patient was involved in delivering care at Heathcote to a migrant woman who was admitted after she had accidentally smothered her baby. The woman was not responding to treatment, so the Aboriginal woman:

turned around and said to the doctors, 'Leave her to me, you don't know what you're doing, you blokes. You don't know what you're doing. I can fix her up.' And this doctor, he turned around and said, 'Anything's worth a go'. She demanded dolls and everything else. Now used to overlook the river, Heathcote, and she used to have her out there, third day she had the patient crying. The next thing you know, this woman's holding this doll; it took a matter of about a week and a half. A month later the woman was discharged.⁷⁴

'Ludwig' also recalled:

I was friendly in Claremont with a schizophrenic Aboriginal man from the Kimberley and used to discuss his culture with him. He was raised in the bush until he was taken to a mission at age 11 so he believed in 'the bush gods when I'm in the bush and the Catholic god when I'm in the city.' ... I had another Aboriginal man there, however, who was psychotic. He told me he could hear the old men saying bad things around the campfire. He responded well to antipsychotic medication.⁷⁵

Apart from the Aboriginal woman who ran away from King Edward Memorial Hospital, only one other informant from this period mentioned an Aboriginal patient absconding:

I remember an Aboriginal patient who was well known to us ... one day he decided he would escape out the back, so he tied the sheets together. He got the chocks off the windows. He went out the window with a sheet, but he forgot to tie it to the bed, and he broke his leg. And that was his story.⁷⁶

The qualitative data seems to confirm that there were very small numbers of Aboriginal admissions to mental hospitals, and that they often had comorbid physical disorders and illnesses. However, the accounts from staff present a marked contrast to the fear-mongering of newspaper reporting in the same period. Staff were aware that Aboriginal patients came to hospital only after their illness had progressed seriously, and that they were sometimes discriminated against in the hospital because of their ethnicity. Aboriginal patients are not described as more dangerous than other patients, and their violence is consistently attributed to being in acute stages of illness. Staff also report friendly relationships with Aboriginal patients, in which there was an exchange of views and understanding which helped the staff to understand the Aboriginal person in their own context and background.

⁷⁴Norm Harley, interview by [article co-author], 20 May 2010, Graylands History Project.

⁷⁵'Ludwig', interview by [article co-author], 10 September 2009, Graylands History Project.

⁷⁶Wayne Endersbee, interview by [article co-author], 12 March 2009, Graylands History Project.

Conclusion

Is it possible to create a meaningful historical perspective on Aboriginal people in Western Australia who were admitted to public mental hospitals? We would argue that it is possible, but only within the limitations described above, as identification was not consistent, and current restrictions on access to records also limit this endeavour. The Australian Bureau of Statistics has warned analysts to use caution when dealing with questions of historical Aboriginal population numbers, as social changes—such as a growing willingness of people to identify themselves as Aboriginal, different data collection methods, and more consistency in record-keeping—can create apparent data anomalies.⁷⁷ This caution should also apply to older mental health records, as it is not clear whether staff members recording the information asked the person whether they were Aboriginal or not, and whether individuals (if asked) would have chosen to answer correctly.

The numbers of identified Aboriginal people admitted to public mental hospitals in this period may have been much larger than those described here. This study had to omit admissions to the Kalgoorlie Hospital and Perth Hospital mental wards (1907–1929), as we were not able to access these records at the time of writing. These two wards treated hundreds of patients annually, most of whom were discharged after very short stays, without certification under the Lunacy Acts. It may be that many other Aboriginal people presented to these services who were not subsequently transferred to Claremont.

A further question is: what can we do with the data on Aboriginal admissions, once we have collected it? Because Aboriginal Australians were not included in national census counts, it has been difficult to match this data to other key indicators of well-being such as participation in employment, as these are similarly under-recorded. Conversely, one area where historical data is over-abundant is that relating to imprisonment. As a result, this dataset raises as many questions as it answers. Were there low rates of incidence of serious mental illness among Aboriginal people in Western Australia, or just low rates of treatment? If the incidence was lower, then what protective factors were operating? Did Aboriginal people with mental illnesses tend to remain in their local communities and be treated there, or in general hospitals, or were they kept instead in lockups, missions and prisons? Finding data to support any hypotheses would require careful investigation of a range of other State-based records, including those government departments which historically managed local Aboriginal communities.

One year, 1967, was a watershed year for Aboriginal Australians, when a national referendum voted overwhelmingly in favour of allowing the Commonwealth government to legislate for Aboriginal people (previously a right only of the States), and for Aboriginal Australians to be included in the national census.⁷⁸ The 1967 referendum seems to have prompted a greater openness among Aboriginal people to be recognised as such, with the numbers of people identifying as Aboriginal doubling between 1966 and

⁷⁷Aboriginal and Torres Strait Islander Commission, 'Statistics on the Indigenous Peoples of Australia', *Year Book Australia, 1994* (Canberra, ACT: Australian Bureau of Statistics, 1994).

⁷⁸Most Aboriginal people had held full citizenship and State-based voting rights for many decades before

this, but many were unaware of these rights. Ron Sutton, 'Myths Persist About the 1967 Referendum', *SBS News*, <http://www.sbs.com.au/news/article/2014/03/10/myths-persist-about-1967-referendum> (accessed 2 February 2016).

1976.⁷⁹ Along with these campaigns for recognition came a drive to repeal the discriminatory prohibition of alcohol for Aboriginal people, which was not well planned or executed in all States.⁸⁰

Data linkage and analysis of post-1966 computerised mental health records in Western Australia may indicate at what point Aboriginal people became more clearly identified and/or more frequent users of mental health services, and whether the high levels of acuity and co-morbidity found in this study persist over time. By matching this data and that from the National Aboriginal and Torres Strait Islander Health Surveys with other social indicators where possible, such as employment participation and imprisonment, we can begin to develop a historically more accurate image of the mental health and well-being of Aboriginal people in the twentieth century, and how they engage with public mental health services. There are other areas where more scholarship is needed, especially if it is possible to capture any remaining oral or written histories which might help to provide authentic Aboriginal voices, and leading to a better sense of what life for Aboriginal people was like in and around these mental hospitals.

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⁷⁹Australian Bureau of Statistics, 'Aboriginal and Torres Strait Islander population', *Year Book Australia*, 2004

(Canberra, ACT: Australian Bureau of Statistics, 1994).

⁸⁰Brady, 'Equality and difference', 760.