

³WALLACE, MARJORIE (1987) A caring community? The plight of Britain's mentally ill. Colour Supplement, *Sunday Times Magazine*. 3 May.

⁴KINGS FUND FORUM (1987) *The Need for Asylum in Society for the Mentally Ill and Infirm*. King Edwards Hospital Fund for London.

De-institutionalisation in Australia

DEAR SIRS

There have been many papers lately in the *Bulletin* describing de-institutionalisation in the USA and other countries. I would like to describe a similar situation in New South Wales which has 5½ million inhabitants, most of whom live around Sydney. The treatment in psychiatric hospitals is provided free of charge by the State Government. There is also a Federal Government Compulsory Health Insurance Scheme called 'Medicare' which provides for 85% of a doctor's fee if the patient wishes to be treated in a private hospital. There are 10 psychiatric hospitals, three of which are in rural areas. Most psychiatric practice in New South Wales has been traditionally centred around large psychiatric hospitals with in-patient and out-patient facilities which catered for a range of disorders including psychosis, mental retardation, organic disorders and drug problems. They also had people needing accommodation over a short period due to social problems. Patient ages ranged from adolescence to the elderly, often lumped together regardless of age or diagnostic category. This resulted in a typical public attitude toward these institutions which were seen as providing a custodial care.

The condition of these hospitals has worried the profession and led to the enquiry in late 1982 which resulted in the *Richmond Report*.¹ The main recommendations included separation of services for mentally ill and developmentally disabled (mentally retarded), a plan to move long-stay patients from hospital to the community, transfer of acute beds from psychiatric to general hospitals, setting up more services in the community and reducing the number of beds in psychiatric hospitals. Two further documents later gave a detailed plan of how to implement these recommendations.

The process started slowly in 1983 and met with problems straight away.

Firstly there was lack of co-operation by the staff employed by psychiatric hospitals, especially nurses. They felt threatened by the report as they saw this as an exercise to close these hospitals altogether and the real aim of the Report was misunderstood.

The second problem was relocation of acute care from psychiatric to general hospitals. The staff at these hospitals were not quite ready for this and found psychiatric patients difficult to deal with.

The third problem, the most difficult, was the transfer of long-stay patients from the hospital to the community. The public was not ready and found it difficult to accept someone they thought of as a hospital patient living next door. This resulted in protests and incidents where public anger was directed at patients.

The fourth problem was financial. As different areas had different approaches to budgeting, some got into serious problems.

Separation of services for mentally ill and developmentally disabled presented difficulty. Some patients with problems in both areas were moved back and forth several times.

In some areas targets were set in that it was decided to move a certain number of patients in a given time which caused difficulty and some had to come back to hospital.

In summary, the *Richmond Report* is a brilliant piece of work and has the aim to improve treatment facilities for mentally ill and developmentally disabled people but its implementation is presenting considerable difficulties. The following steps will be necessary to implement it properly:

- consultation with the employees of State Psychiatric Hospitals, especially the nursing staff, to relieve their anxieties and have their full co-operation. Some consultation has taken place, but more is needed;
- to educate the public about the real aim of these changes and the rights of the mentally ill with the aim of achieving a more flexible attitude;
- to modify the plan of services for the developmentally disabled with more involvement of a psychiatrist rather than leaving the whole to paediatricians and physicians;
- to provide advice to the general population and specialists about their roles;
- above all, to allocate more money for community services and provide a better patient support system.

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REFERENCE

- ¹*Richmond Report* (1982) An official document by the Department of Health, State of NSW, Australia.

Admission for assessment or treatment?

Sections 2 and 3 in perspective

DEAR SIRS

Recent correspondence from Dr Aaronicks (*Bulletin*, June 1987) and Dr Bermingham (*Bulletin*, November 1987) emphasises the confusion and diversity of practice concerning the compulsory admission of the mentally disordered into hospital.

Many social workers with the support of some consultants and apparently with the approval of the Mental Health Act Commission apply for admission for assessment (S.2) in preference to admission for treatment (S.3) even when the nature and degree of the mental disorder is known, and the real purpose of the admission is for a continuation of a programme of treatment well established during previous admissions of the patient suffering from the same disorder.