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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

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Admission for assessment or treatment?

Sections 2 and 3 in perspective

DEAR SIRS

Recent correspondence from Dr Aaronricks (*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.

There appear to be two reasons for this attitude. In the first place the procedure is easier to invoke (for example there is no need for the nearest relative to be involved prior to a S.2 application). Secondly, and of greater relevance, is the belief that it may be "kinder" to the patient to be able to say that detention under S.2 is for a maximum of 28 days, whereas detention under S.3 may be for six months. This attitude seems to be somewhat cynical in the case of a patient whose problems are already understood, and in respect of whom it is anticipated at the time of admission that S.2 will in due course be followed by S.3 as the disorder is unlikely to be relieved within the first 28 days.

One drawback of using S.2 is that, by the end of the 28 day period, the patient may be too well to be further detained but not well enough to be discharged. Such a patient may take his own discharge and, due to lack of insight, refuse further medical treatment, leading inevitably to rapid relapse and early readmission which, if again under S.2, may lead to a repetition of this unfortunate scenario.

Clearly if such a patient had been admitted under S.3 the treatment could have been prolonged for as long as appropriate, thus allowing the patient to enjoy an improved state of health with fewer distressful admissions.

To some extent this diversity of practice arises out of a lack of clarity in the Mental Health Act 1983.

The term "medical treatment" is expressed in S.145 to include "nursing care, habilitation and re-habilitation under medical supervision". Apart from that there is no statutory definition of either "medical treatment" or "assessment".

It will be generally agreed that medical treatment will at all times include an element of what may popularly be called "assessment". In other words, throughout the treatment programme a medical team will continuously monitor the course of the disorder and adjust the treatment as appropriate. It is clear from the context of S.2 that "assessment" for the purposes of the Act has a very particular meaning, and is not used in the popular sense described above.

An application for admission for assessment may be made on the grounds that the patient "is suffering from mental disorder of a nature or degree which warrants (his) detention in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period."

The use of the expression "for assessment (or for assessment followed by medical treatment)" gives rise to some difficulty of construction. On the face of it the expression would appear to imply that a patient admitted for assessment will not receive any medical treatment unless the assessment is completed before the section runs out when the assessment may be "followed by" medical treatment. However S.63 makes it clear that a patient detained under S.2 may be the subject of medical treatment without his consent at all times throughout the period of detention.

There can be but one explanation for this apparent contradiction and that arises out of the distinction between the criteria for admission under the two sections.

A patient may be admitted to hospital pursuant to S.2 if he suffers from *any* form of mental disorder. A patient may be admitted pursuant to S.3 only if he suffers from one or more of the four specific categories of mental disorders set out in the section, namely mental illness, psychopathic disorder, severe mental impairment or mental impairment.

The process of assessment is clearly the process of identifying the nature of the disorder from which the patient is suffering to establish whether the criteria for admission for treatment under S.3 have been satisfied.

In other words the use of S.2 is appropriate only for the purpose of diagnosis to establish the classification of the disorder and whether or not the provisions of S.3(2) are satisfied, i.e. to establish whether the nature or degree of the disorder make it appropriate for the patient to receive medical treatment in a hospital; and in the case of psychopathic disorder or mental impairment whether such treatment is likely to alleviate or prevent a deterioration of his condition; and whether it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained *under S.3*. ("under *this* section" S.3(2)(c)).

It is therefore wholly inappropriate to admit to hospital pursuant to an application for admission for assessment any patient suffering from a form of disorder the nature and degree of which are already known to the Responsible Authority. There can be no assessment if the nature and degree of the disorder is already established. Any contrary view would enable the compulsory admission under S.2 for the purposes of medical treatment, patients suffering from a form of disorder other than one specified in S.3. This might be considered to be an abuse of power.

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Section 37 of the Mental Health Act

DEAR SIRS

I read with interest Dr Singhal's letter on 'Section 37 of the Mental Health Act 1983' (*Bulletin*, January 1988). A patient detained in hospital under Section 37 may apply to the Mental Health Review Tribunal for his discharge in the second six months of detention and has a further right to do so within each subsequent period that the detention is renewed is clearly detailed in the Mental Health Act 1983. In his letter Dr Singhal raises the question whether such patients can apply to hospital managers for their discharge within the first six months. In my opinion the answer seems to be 'yes'. To this effect I would like to draw his attention to leaflet 8, *Your Rights under the Mental Health Act 1983* paragraphs 3 and 4 which clearly states:

Para 3: "The doctor will tell you when he thinks you are well enough to leave hospital. If you want to go

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