Richmond Revisited

Judge Frank Walker QC is currently a judge in the Dust Diseases Tribunal, but his career of public service, both as a State and a Federal parliamentarian, precedes all that. The main reason for his attending tonight is that he is President of the New South Wales Schizophrenia Fellowship.

Judge Walker: I really haven't much criticism of what I have just heard from Maurie Sainsbury, but I certainly have a very different perspective. Given that the object of the Society is scientific learning, I should preface my remarks by explaining some aspects of my history and training that might assist my audience to give appropriate weight to what I say.

My legal background.

I am a District Court judge, working in mesothelioma cases most of the time. District Court judges in their daily working, in both criminal and civil cases, regularly come into contact with parties or witnesses suffering from a mental illness. From time to time, my brother judges form the view, on the medical evidence before them, that these defendants are a danger to themselves or to others and should be diverted into medical care. They find it necessary, pursuant to the provisions of the Crimes Act, to refer them to psychiatric hospitals.

In conversation with judges, both as President of the Schizophrenia Fellowship and as a brother judge, they tell me that their complaint about the system is that the people they divert return like boomerangs. Almost the same day, at times, defendants have been sent back from psychiatric institutions, with the comment that they were not in need of medical treatment, despite the fact that eminent psychiatrists in the State had found them to be suffering from very serious mental illness at the time. That produces a great deal of frustration in judicial officers, particularly magistrates. Many now refuse to take part in the diversion provisions of the criminal law.

My civil libertarianism

I should also confess that I am a longstanding member of that chattering class of lawyers who proudly proclaim themselves to be civil libertarians. My interest in mental health matters was first aroused by the human rights abuses occurring in our mental institutions in the 1960s and 70s. My particular bugbear was medical experimentation, particularly psychosurgery and ECT, performed on involuntary patients incapable of giving informed consent.

In more recent times, I have been known to raise my voice against human rights abuses in refugee detention centres and against suspected terrorists. Like most lawyers, I am appalled at our politicians rushing headlong to create a police state in Australia, a country which used to pride itself on its tolerance and freedom of expression. I have been particularly horrified at the way mentally ill folk, and Cornelia Rau is one of some 200 examples, have recently become victims of these oppressive measures.

My political background

Next, I was a politician for 25 years. Worse still, at the time of the Richmond reforms, I was Attorney-General of New South Wales and a member of the Wran Cabinet. I was an enthusiastic supporter of de-institutionalisation, as was every one of my colleagues. It was our unanimous decision to support the Richmond Report. As such, I accept collegiate responsibility for our government's egregious failure to properly fund the community care side of those reforms, leaving us with a mental health system that is still in crisis. Mind you, the same criticism should be levelled at the subsequent Unsworth, Greiner, Fahey and Carr governments, which happily compounded our errors. I should pause a moment to mention the arguments of politicians such as

the former Premier, Bob Carr, who proudly proclaimed on television, just before he resigned, that the New South Wales mental health system was the best in the world. Later I will explain why I think it is dysfunctional.

My experience as a carer

My third disclosure is that I was the carer of two sons with serious mental illness. Both were failed by the New South Wales health system and both suicided. My carer's role gave me a personal insight into the shortcomings of our mental health services. Briefly stated, even with my background, I found it extremely difficult, and often impossible, to secure my sons' admissions to psychiatric units in a general hospital, despite the fact that they were psychotic at the time and very dangerous to themselves. On two occasions, they were denied admission immediately after a suicide attempt. On the occasions when they were admitted, I found them to still be delusional when they were released back into the community.

Often I was not informed of their release, despite being responsible for their admission and despite my visiting the hospital on a daily basis. Indeed, extracting any information from psychiatric registrars about my sons' mental state, medication or plans for ongoing treatment was virtually impossible. One of my sons had an alcohol addiction; our state hospitals provide no rehabilitation for mentally ill folk with a dual diagnosis. I gained the impression, over some two decades' experience with the mental health system, that the Health Department found it more convenient to pass the buck to parents, charities and the criminal justice system, rather than to make a genuine attempt to provide an adequate mental health service.

My activism

For the past decade, I have served on the board of the Schizophrenia Fellowship of New South Wales. During the last six years, I have been its president. I have also served on the national executive of the Mental Illness Fellowship of Australia. In these roles, I have had frequent contact with large numbers of sufferers of schizophrenia and their carers. Their stories are no different from mine.

The numbers

Social service agencies estimate that there are about 50,000 mentally ill folk living either rough on the streets of Sydney, in substandard boarding houses or incarcerated in our prisons. Few of those unfortunates receive medical attention for their mental condition.

The 1,400 hospital beds available in New South Wales to service about 70,000 psychiatric patients a year are grossly inadequate. Our annual needs, depending on whose statistics you believe, range between 250,000 and 500,000 people in New South Wales who, from time to time, have a significant mental illness. There is a critical shortage of psychiatrists and mental health nurses in those psychiatric centres, and even if more beds were provided at the moment, the chances are they would never become operational. While the crisis care beds provide clinical psychiatric treatment for some critically ill patients, for short periods-very short periods-there is no rehabilitation generally available for patients with a mental illness in New South Wales.

The remainder of folk with a serious mental illness, depending on one's definition of 'serious', constitute somewhere between 50,000 and 100,000 people. They are currently cared for either by their families or friends or by specialist non-government organisations, such as the Richmond Fellowship and After Care. With the exception of a handful of patients who are just coming into the Iemma Government's supported housing initiative, called HASI, none of these folks are receiving intensive clinical care, with the exception of some patients in experimental university

trials. Essentially, nobody in New South Wales with psychotic mental illness receives clinical rehabilitation.

A fair go

Traditionally, Australians have been committed to the concept of a fair go. At this point I would like to give you a simple example, as I do at gatherings like this, of why I believe that New South Wales citizens with a mental illness are not getting a fair go.

If you were critically injured in a motor vehicle accident and rushed to hospital in a coma, you would immediately be placed in an intensive care ward where you would receive 24-hour care from the best specialists and most highly trained nurses our health system has to offer. When you emerge from the coma and your physical injuries are attended to, a wide range of rehabilitation services would be made available to you, including physiotherapy, cognitive therapy of speech therapy. That treatment would proceed until either you were cured or your doctors concluded there was nothing more to be done for you. Such treatment sometimes goes on for years.

On the other hand, if your potentially critical injury was caused by mental trauma and the suicidal urges threatening your life were the result of brain dysfunction, then, notwithstanding how critical your condition, there is no guarantee that you would even get a hospital bed, nor if you did, that you would be allowed to stay in it for any length of time, certainly not until your psychosis resolved. What is guaranteed is that you wouldn't receive any rehabilitation.

Short-stay in mental hospitals

Figures on the average stay of patients in psychiatric beds are hard to come by. I am told that, in recent times, the average stay in a psychiatric bed is between four and seven days. This is only an average. As Maurie told you earlier, there are many very elderly dementia patients who stay in for long periods of time, making that 'average' a bit dubious as a generalisation. Most get evicted from their beds within a week, well before any psychosis can be controlled. Tragically, many are returned to the streets, only to cause harm to themselves (including suicide) or to others.

Prisoners with a certified mental illness

I mentioned earlier the large number of prisoners with a certified mental illness. My source of statistics here, Forensic Health, indicates that the proportion of mentally ill people in our prisons, that is, people who tell the researchers that they have a certified, recognised mental illness, is about 50 per cent for men and about 60 per cent for women. They have been doing these figures for a few years now, since the late 80s, and the percentages have been increasing. It is certainly a very significant figure. Not all of them are sick at any one time, but there are a great many people in our prisons, with very serious mental illness, who are totally untreated for it. There is only a handful of beds in the whole forensic service, something like 40-odd beds, I think, for mentally ill people.

My former occupation gives me a cynical insight into the workings of the bureaucracy and their political masters, and that is why I note that, while it costs something like $240,000 per annum to service a psychiatric bed, it costs the Prisons Department only $80,000 to look after a prisoner. Inevitably, political policy is dominated by the availability of funding and the priorities of the government of the day. Ultimately, the reason why we have such a dysfunctional mental health service is because the New South Wales and Commonwealth Governments spend only eight per cent of their total health budget in the area. To put that figure in perspective, I should tell you that most comparable developed nations, including the USA, the United Kingdom and New Zealand, spend more than twice that amount. I should also point out that the Commonwealth

figure is also very dodgy, because the Commonwealth, in an endeavour to gild the lily, includes expenditure on nursing homes, developmental disability care and drug and alcohol programs in the category of mental illness.

The background to the Richmond Report

The stigma of mental illness

From primitive times, great stigma has been associated with mental illness. Early human societies believed that mentally ill folk were possessed by demons. Early Christian societies believed them to be the spawn of the devil and consequently visited terrible violence upon them, including burning them at the stake. It was not until the Elizabethan era that a slightly more civilised attitude prevailed, when Good Queen Bess, who had some problems with madness in the family, decreed that mental illness should be treated as a social problem. The perceived social 'problem' wasn't the care of the affected person. It was the protection of the reputations of the nobility and of the wealthy classes. The solution was to establish 'mad houses', in which the embarrassing relatives were locked away. Later, the British Government constructed lunatic asylums for the rest of the community. As Charles Dickens tells us, those institutions were terrible places indeed, where the inmates were treated even more inhumanely than criminals in a prison.

Early developments in NSW

We imported all these inhumane attitudes and practices into the colony of New South Wales. Typically, it was Governor Macquarie who attempted to leaven the situation by exempting lunatics from the daily whippings administered to vagrants. He arranged for the first asylum to be built at Castle Hill in 1825. His work led to lunacy laws being passed in 1843 and 1878; laws more concerned with preventing avaricious relatives putting family members away to get their hands on their fortunes than with protecting patients.

The maltreatment scandal

Not until 1959 did the (Cahill Labor) government enact laws establishing the principle that treatment in institutions be based on care, not confinement. Those responsible for the administration of the Health Department seemed to have a lot of trouble understanding the spirit of that legislation, however, because both that government and the Renshaw Government which followed were rocked by a series of scandals associated with the maltreatment of inmates in asylums. Headlines in the Sun and Mirror screamed about widespread physical and sexual abuse, sedation of inmates to the point where they became zombies, illegal medical experimentation, poor food, inadequate and inappropriately qualified staff and criminality amongst the staff, including stealing prisoners' food and provisions. Shocking revelations before the Royal Commission into Callan Park in 1961 generated a political movement among the families of the patients and concerned health professionals. That movement, cognisant of the highly successful community care system established in the United Kingdom, lobbied politicians for reforms along the same lines.

The government's response

It wasn't until the 1980s, when Laurie Brereton became Minister for Health (very unpopular with the medical profession, but very popular with consumers in the mental health field) that the Richmond Inquiry was established. Unfortunately, as always, mentally ill people lost again; by the time Cabinet came to implement the report, Laurie had moved to another portfolio. I know him well and believe that, committed as he was to the reform of our mental health laws, he

wouldn't have tolerated the funding fiasco that developed over the ensuing years concerning the non-provision of community care.

Funding

It is important to understand that David Richmond's funding recommendations applied both to psychiatrically and developmentally disabled persons. Many in the field would suggest that the overall funding was never enough, but the lion's share did go to those with developmental disability, who deserved every cent they got. The report recommended that the health budget be re-divided to allocate a greater share to mental health to pay for the closure of the institutions and for the provision of intensive community care. That happened, but only years later. In 1983, substantial sums for the provision of community care were recommended from within existing resources as well as from additional funds-'new' money. What actually eventuated was that, following the Richmond recommendations, only 208 persons of the 6,000 left in institutions were released into the community. The rest were 'institutionalised', and never released into the community. Some are still there. There was no significant increase in the proportion of the health budget for mental health. The miserly 'new' funds went to improving the psychiatric units which had already been set up.

The inmates

I think it is most significant that the Royal Commission into Callan Park noted something like 17,000 inmates in the asylums in 1961, but they weren't all mentally ill. This figure included about 5,000 developmentally disabled people, many of whom were senile dementia patients. By 1983, at the time of the Richmond Report, despite a substantial increase in the population of NSW, only 6,000 inmates remained. This was because the New South Wales Health Department had been actively pursuing de-institutionalisation in response to the scandals which had precipitated the royal commission, and because some Federal money had been pumped into their pockets. They had also been developing psychiatric units in the mainstream hospitals.

The chances are that some of the 6,000 inmates in institutions at the time that Richmond delivered his report did not really need to be there in the first place. Many had probably gone in with a condition which could easily have been resolved, but by the time of his report, most were institutionalised and unable to re-integrate into the community. Richmond's recommendations to raise substantial funds for community care by selling extremely valuable real estate upon which the institutions were located did not come to pass. Two things prevented this: they needed the institutions for a long time to keep the 6,000 odd people who were there, and the politics of selling those green spaces and lovely historic buildings was too hard for the government. But Richmond had recommended that they be sold and the money put into the provision of community care.

New mental health patients, unable to secure admission either to the institutions or to the seriously under-resourced psychiatric units, gradually filled the streets of Sydney and the larger regional centres unless they were lucky enough to find accommodation in the rapidly diminishing, substandard boarding houses or unlucky enough to be thrown into prison.

In other words, despite Cabinet's enthusiastic endorsement of the Richmond Report, its fundamental recommendations concerning the implementation of community care were never implemented; twenty per cent of our population of seriously mentally ill people were callously condemned to live in the same places where our forefathers in our fledgling colony had condemned their lunatics, namely the streets and parks of Sydney.

Today's problems

St Vincent de Paul tells me there are now 20,000 people living rough on the streets. The reason we have so many has nothing to do with the Richmond Report; it is all to do with the Mental Health Act 1984 which went through Parliament at the same time, with definitions which empowered registrars in psychiatric units to be the gatekeepers. The mentally have gradually filled our streets over the last two decades; that legislation is why we have so many there. It has nothing to do with David Richmond, but everything to do with some rather callous decisions by the Health Department to put out into the community people who really should be receiving treatment, simply because they have never had the resources and have never been prepared to ask for the resources needed to solve the problem.

New directions in 2004

It is pleasing to note that the new Premier, Morris Iemma, commenced office by announcing that his number one priority would be to deliver a better deal for sufferers of mental illness. I can tell you that my organisation was overjoyed. Morris has followed the announcement with the development of a scheme called the HASI scheme, the sort of thing that David Richmond wanted. It provides, for the first time, albeit on a pilot basis involving only some hundreds of people, the development of intensive care for seriously mentally ill people living in the community. I speak of people with serious mental illnesses, not young people with a slight depression: I am talking about people with delusional behaviour, suicidal indeation and the like.

Why did previous governments get it so wrong?

Why did five previous governments fail so miserably to deliver that care? Well, money is the root of all evil and there was an exponential blow-out in health care costs when I was in Cabinet. There were huge increases in line items, particularly doctors' and nurses' salaries; in the cost of medical technology and the cost of constructing new hospitals, to keep pace with the increase in population. That forced all those governments to put their cards on the table to show where their priorities really were. The result when the cards hit the table was that the sufferers of mental illness were relegated to the bottom of the priority list and got virtually nothing. Since 1983, there has never been a suggestion from the leadership of the Health Department or from its Ministers, that the concept of community care should be rejected.

An opposing view

There is a small lobby of psychiatrists and health workers who argue that Richmond was wrong, despite the overwhelming evidence to the contrary to be found in the United Kingdom and New Zealand, where community care is paid for under the national health service and where GPs refer their patients to community care. It is their view that we would be better off returning to the large institutions, provided that we ensured that they were properly resourced and humanely administered. I think that Dr Barclay might also have suggested, at one stage, that we should return to the large institutions, which were cheaper to run and more efficient.

Asylums inappropriate

Richmond rejected the view that it was better to return to the large institutions. He pointed out that, even in 1983, some 90 per cent of people with mental illness were being treated outside the asylums. Further, he emphasised, as I have done this evening, that there was no scientific basis for creating institutions, because they weren't created as a scientific way of treating people with mental illness. They were created to sweep people's embarrassing relatives under the carpet. Like the prison hulks and orphanages in 18th century Britain, asylums were created because of a perceived social problem, not to look after the interests of their inmates. Indeed, as David

Richmond pointed out, all the research available to him strongly supported community care; no research supported institutions as a model.

Over the last 22 years, of course, scientific research has only confirmed the validity of Richmond's decision. The intractable problems of large institutions are well documented. They have many failings, not the least of which is the psychological condition described as 'institutionalisation'. They are demeaning of human dignity and crushing of human aspirations; and bureaucratic cost-cutting inevitably leads to the quality of their services declining as the years go by.

Social justice

My belief is that social justice demands that mental health patients have the same level of care as other sick Australians. That includes access to hospital beds and rehabilitation services and therapies and to any other services necessary to allow them to live their lives in dignity within the community. Burying citizens, who have committed no crime other than being ill, in institutions is to my mind unconscionable.

That is not to say that there aren't a very small minority of severely affected victims of mental illness who need continuing and perhaps life-time care. It would be a monstrous miscarriage of justice to condemn the 20% of Australians who suffer symptoms of a recognised mental illness during their lifetimes to institutions because a few need full-time care. The efficacy of modern antipsychotic medication and antidepressants is such that even sufferers of severe schizophrenia and major depression can still enjoy long periods when their condition is successfully controlled. Indeed most of them have no need to be admitted to hospital on more than one or two occasions annually. For the rest of the year, they are able to enjoy life in the community, to live independently and even to hold down a job. Others are able to get by with dignity living in group homes supported occasionally by health professionals and social workers.

The way forward

The vital question is: where should we go from the current crisis in our mental system to deliver justice to the hundreds of thousands of Australians suffering mental illness? Before I briefly suggest solutions, I suppose I should face up to two realities.

It is now two decades since the Richmond Report. Medical science and particularly neuroscience have been making great leaps forward. I still share the view that psychiatry is an art, not a science, but concede that we are getting closer to an understanding of the precise mechanisms causing mental illness. Nevertheless we can only treat the symptoms, not the causes, of serious mental illness. For the great majority of patients, the only therapy available is pharmaceuticals with fairly horrific side-effects, some worse than most other diseases. I appreciate that psychologists are experimenting with promising cognitive therapies and improvements in ECT seem to be having good results, particularly with chronic depression. My point is that now that psychological and psychosocial therapies are becoming more available, David Richmond's recommendations for intensive community therapy are more valid than ever.

New money needed

Because five previous NSW governments failed to find the modest sums recommended by Richmond, the cost of providing the full range of community care in 2005 would amount of hundreds of millions of dollars. Such funds, with the best will in the world, will not be found overnight. They will need to be phased in over some years if community care is to be realistically achieved. One approach, the one we use, is to ask the government to plan to bring the mental

health budget up to the levels of comparable developed nations. Even some non-comparable underdeveloped nations, such as Sri Lanka and Bangladesh, spend a higher proportion of their limited health budgets on mental health than we do. Perhaps they have some overseas grants. But as Richmond realised, the funding issue is not only about having recurrent funding at the right level, but also that you are going to need a substantial amount of capital if you are going to expand a state-wide network of community care facilities.

A better model of community care

The HASI (Housing and Accommodation Support Initiative) scheme recognises that community care has to be delivered at three levels-intensive, moderate and low-to meet the differing needs of patients and their illnesses. HASI provides housing and supported care, be it of a medical or social nature. If we are to get large numbers of mentally ill folk off the streets and out of substandard boarding houses, then we need to develop a more holistic approach to their needs. Without going into great detail, our Fellowship would argue that the basic structure of a successful scheme would be along the following lines:

Put a roof over the patient's head

Government funding will be required to provide a range of public community and private housing options. Recently, I suggested to the Parliamentary Secretary for Health that the Federal Government should put more money into housing. They have been taking it out in recent years, particularly out of housing for people with disabilities and particularly for those with mental illness. He said that it was unconstitutional, the government didn't have the constitutional power to pay for such services. But they do, and I think that the Commonwealth Government could be a very important player in this role.

Socialisation and the learning of independent living skills

These two factors are of crucial importance if the patient is to survive in the community and move on to develop friendships and relationships as well as being trained for employment. The clubhouse movement, which our Fellowship supports, provides all those things.

Intensive community care

This will be needed for those with a serious mental illness causing psychosis warranting hospital admission a few times a year. It might be clinical or psychosocial, but we need such care. Recently published studies have shown tremendous results, even with very profoundly affected people. Medication is important to get people stable, but if you are going to get them back into a more normal living style, other forms of rehabilitation are going to have to be funded. Our Victorian counterparts are doing just that. They have a system called 'step up, step down'. That involves group homes, recommended by Richmond, that we were talking about earlier. People are cared for there, but when they go through these periods of deep psychosis, there is a partnership with the Health Department which immediately accepts their transfer to a psychiatric unit, where they stay for two or three weeks until their psychosis is sorted out and they are transferred back again to the units-'step up, step down'. It seems to be working tremendously well, so well that the Victorian Health Department is talking about reducing its psychiatric beds because they are no longer needed.

That arrangement is also assisting to reduce the number of suicides. As you know, there is a very high suicide rate with diseases like schizophrenia. It is being reduced by that sort of approach, by that sort of management.

Patients with a dual diagnosis

When we are establishing community care units, we need to do something about patients with a dual diagnosis, those who are drug or alcohol addicts as well as having a mental illness. The way you get cured of alcoholism or drug addiction today is basically the AA steps to recovery. With great respect to that true and tried model, its success depends to a very great extent on the addict learning the personal disciplines and controls necessary to break the addiction. It is just not reasonable to expect persons with a serious mental illness to be able to control themselves to that extent. New ways need to be invented. I understand that Westmead Hospital is working on one of them at the moment. The Health Department needs to come up with something to sort out those people with a drug addiction because there are large numbers of them, with alcohol probably the commonest drug of addiction.

Employment

Employment is an essential element in maintaining the dignity of modern humans. New models of care will have to provide linkages with specialised work training and job search.

Psychiatric units in general hospitals

Finally, something is going to have to be done about psychiatric units in our public hospitals. Not only is there a chronic shortage of beds, but a more serious shortage of trained and interested psychiatrists and mental health nurses. Carers frequently tell me that some of our psychiatric units are left without properly qualified supervising psychiatrists for long periods of time and are otherwise badly staffed. I appreciate that a lot of the problems about nurses are coming from the Federal Government and the universities. However, I think it is deeper than that. I think there is just a reluctance of nurses (and medical practitioners) to enter a system which they perceive to be in crisis. Wholesale recruitment of foreign professionals is a solution in vogue at the moment. It might be a short-term solution, but it has its downsides, as the Queensland government has recently found out. Greater effort needs to be made to train Australians in the field of mental health and perhaps in developing an education campaign to encourage more young people into the field.

Crisis care teams

We also hear alarming reports concerning crisis care teams, some of which do not work on weekends or at nights. My experience as a carer is that it was the weekends and the nights when you could expect most of the problems to exacerbate. There needs to be a standardisation of the quality of care here.

Conclusion

In conclusion, returning to the title of this evening's discussions, and succinctly stated, I strongly hold the view that the Richmond Report desperately needs re-visiting. It also needs revising to bring it up-to-date with modern medical science. Most of all, the government has to find the wherewithal to throw lots of money at the development of an effective intensive community care system to relieve pressure on hospital beds, as well as doing something for the tens of thousands of victims of mental illnesses living rough out there in the community.