

Richmond Revisited

Dr Maurice Sainsbury has had a distinguished career as a psychiatrist, both in the public health system and as an academic through his directorship of the Institute of Psychiatry, which provided the training program of the Royal Australian & New Zealand College of Psychiatrists, and as a past President of the College.

Dr Yvonne Skinner telephoned me some months ago to ask if I could suggest someone to speak on changes since the Richmond Report. This was followed by a comment on the effect of putting people out in the community. Then I was asked if I had read the Weekend Australian of 16 and 17 July, 2005, on the Richmond Report.

Blaming Richmond

As I hadn't, I borrowed a copy and read some amazing statements, such as the quotation from Federal MP, Peter Brien, "The prisons are doing the jobs of psychiatric hospitals. They have emptied out all their patients after the Richmond Report". This appeared to be pointing the finger at Richmond, blaming him for increasing the prison population.

To quote another statement from the same paper, "A recent study by the Corrections Health Service found that 74 per cent of prisoners in New South Wales suffered from a psychiatric disorder, with almost 10 per cent suffering symptoms of psychosis". I thought things over and felt that I should perhaps accept Yvonne's invitation to speak. I don't intend to refer to the comments in the Weekend Australian at this stage. That will keep until later.

I would remind you, however, that in the late 1980s, it was fashionable to blame Richmond for the homeless, with particular reference to the Matthew Talbot Hostel. Radio commentator Brian Bury used to make my hackles rise when he promulgated that view.

Events before Richmond

The true facts are that, following the Callan Park Hospital Royal Commission in 1961, the 5th Schedule hospitals were disgorging their populations into the community from 1962 until 1976, but mainly in the early 1970s, following an infusion of Whitlam money. This was the so-called 'de-institutionalisation' process, when many were discharged under the guise of being rehabilitated. This occurred mainly in the 1970s. The Richmond Report was not released until March 1983. Nevertheless, some people still lay the blame for our homeless and mentally ill being on the streets at Richmond's feet. Actually, the de-institutionalisation process was blessed by many psychiatrists, believing that it was better for the patients, and it relieved the shocking overcrowding in our psychiatric hospitals.

That this process was an Australia-wide phenomenon is born out by OECD Health Data (1999) which revealed that, from 1960 to 1995, psychiatric bed numbers in Australia dropped from three per thousand to less than 0.3 per thousand.

Facts and figures

My early attempts to find some solid figures dealing with the discharge of patients from the New South Wales psychiatric hospitals from 1960 onwards were not successful. The Data Collection Unit of the Department of Health threw little light on the subject. Annual reports of the Health Department and the Health Commission were of little use, as they gave no 5th Schedule hospital figures for patients in residence until 1982. Freedom of Information returned my cheque for \$30 saying, "No documents will be released" and referred me back to the Department of Health.

Internet research showed no Department of Health statistics until 1996. I would be interested to know the story behind these disappearing statistics.

My statistical saviour was Dr Bill Barclay, a past Director of State Psychiatric Services and later a Health Commissioner. Bill kindly provided me with details of a Schizophrenia Australia Foundation survey dated 1994, and other useful material.

In 1960, there were over 12,000 5th Schedule hospital beds occupied in New South Wales. By 1984, the year the implementation of Richmond recommendations commenced, as I shall indicate later, there were 3,824 patients with psychiatric diagnoses in residence in 5th Schedule hospitals. So, even before Richmond initiatives got under way, patient numbers had already dropped over the preceding 24 years by around 68 per cent to 8,174, that is, by approximately 340 patients per year.

After Richmond, this devolution of 5th Schedule hospitals continued at a lesser rate, to the tune of 140 patients a year. With these figures in mind, any thinking person can hardly blame Richmond for the homeless mentally ill in New South Wales.

The problems in 1982

What was Richmond faced with when he began his inquiry on 13 December 1982? We all know the term 'institutionalisation'. It was introduced into the medical literature in a Lancet article in 1955 by an erstwhile mentor of mine, Dr Denis Martin. The end result of the process, to quote Martin, was "a patient, resigned and co-operative, who had ceased to question his position as a patient, and who becomes too passive to present a problem of management; (and) has in the process, of necessity, lost much of his individuality and initiative". This was one picture confronting Richmond when interviewing the remaining patients in the back wards of our 5th Schedule hospitals.

Another fact of life was that in 1980, 70 per cent of admissions to major psychiatric hospitals were re-admissions. It was seen that there was a need to improve the lot of long-term patients by developing suitable services in the community, outside the entrenched culture of the traditional mental hospitals. Also, the provision of suitable post-discharge services in the community might halt or at least slow down the necessity for re-admission to hospital. Perhaps both of these objectives could be achieved by the development of suitable community services.

Richmond consultations

Those of you who familiar with the Richmond Report will know that it was produced with a background of literature reviews and with 310 submissions received from non-Government organisations (NGOs), professional groups, industrial associations, individuals, et cetera. You will know that 40 visits to relevant services were made, nine formal meetings were held with representatives of departments, Local Government and Shires Associations, and four forums dealing with industrial relations, management, NGOs and community groups.

It was flat to the board for almost seven months. During this time, I was one of the two assessors on the Richmond Inquiry, having been nominated by the Health Commission of New South Wales. The other assessor was Mr Terry Conoulty, a registered psychiatric nurse, nominated by the Labour Council of New South Wales.

I see no point in dwelling on the submissions, save to say that the inquiry had to juggle its way between opposing points of view, such as maintaining the 5th Schedule institutions to provide every form of care and developing crisis and community services.

Successful community living

One particular visit stands out in my mind as it was a new experience for me. We were served afternoon tea by four or five delightful young Down's Syndrome ladies in their home in the western suburbs of Sydney. They had been inmates of the old Rydalmere Hospital. Their movement into the community occurred as a result of the efforts of Mr Glen McIntyre, a clinical psychologist and Programme Director of the Handicapped Persons Unit at Rydalmere Hospital. It was a foretaste of what David Richmond recommended, namely, the development of small community residential units for the severely disabled, particularly the severely intellectually handicapped and those with severe physical conditions, both children and adults, who are unable to continue living with their families.

Questionable standards

In one Sydney municipality, three of 'notorious' boarding houses were visited. The facilities, staff and food in one were adequate, and a second just passable. The third had shocking, unclean toilet facilities, was supervised by an untrained worker and the boarders received one egg a fortnight if they were lucky. Limp vegetables were purchased in bulk from the markets.

Implementation of the Richmond Report.

In 1984, the Richmond Steering Committee was set up. It was chaired by David Richmond, Secretary of the Department of Health from mid-1984 until mid-1986. Later, Bob McGregor became chairman; his associate chairman, Mr Tim Wootton, ran most of the meetings. An offshoot of this steering committee was the Richmond Implementation Committee, commenced by Mr Alec Glen, Regional Director of the Inner Metropolitan Mental Health Region. When Tim Wootton returned from a Churchill Fellowship in August 1984, he was asked to head up this committee. He became Executive Director of the Richmond Implementation Unit. During Wootton's time running the unit, over 100 psychiatric patients were moved from long-term institutional care into supported accommodation in the community with living skills support. These people were followed up for the next three years that Tim Wootton was in head office and were still in the community at the end of those three years. The Richmond Implementation Unit was wound up when Tim left on 27 August 1987.

The closure of hospitals

Richmond at no stage proposed the closure of all large hospitals. What he proposed was a reduction in the number of beds in the large psychiatric hospitals in parallel with the provision of alternative community care. He advocated the moving of acute services to general hospitals and that 5th Schedule hospitals be associated with general hospitals, both falling under the same hospital or area board. He proposed a chain of care ranging from community assessments to the development of a chain of supported care in the community.

"Fundamental to the Richmond Report philosophy was the notion of a network of community based services including hospital care, health teams, supported houses, rehabilitation services and crisis care." (Ref. 2)

Funding

To do this, his funding model was to skim half a per cent off the 2nd and 3rd Schedule hospital budgets to develop the required community services. Seeding money had been provided by Treasury to start the process, but when Richmond's model was not accepted by government, services became critically under-funded.

Richmond's achievements

I would like to add a comment on what was achieved following the Richmond Report and then deal with some stumbling blocks to the implementation of his recommendations.

The developmentally disabled

Prior to the Richmond Report, there were no alternatives for the developmentally disabled other than institutional care carried out by nursing staff. For the first time, people were identified as requiring different management from that required for the psychiatrically ill and the foundations were laid for care to be as homelike as possible. In 1985, the Department of Health set aside money for developmental disability services and developed a separate budget for these services. Developmental Disability Services separated from Mental Health Services in 1987 and came under the umbrella of the then Department of Youth and Community Services in 1989.

A new category of direct care staff emerged, the 'residential care assistants', who were employed in developing community residential units-both being innovations recommended by Richmond. Movement of the developmentally disabled from institutions into homelike residential units began in 1985 and carried on until funding was withdrawn between the late 1980s and early 1990s. I won't mention who was Premier at that stage.

In August this year, I rang a number of locations where developmentally disabled people are housed in order to determine the extent of devolution of institutional care. In 1980, there were 2,583 developmentally disabled people in institutional care. This has dropped to 1,191.

Institution	No. in 1980	No. in 2005
Bloomfield (Riverside Unit)	198	72
Rydalmere & Marsden	871	405
Kenmore (Strathallan Unit)	200	0
Stockton	844	462
Peat Island	174	92
Macquarie (Lachlan Unit)	88	63
Morisset (Kanangra)	208	97

There are probably still 1,300 or so in old traditional care; it would seem that, in many cases, the only way out is by dying. This figure flies in the face of the New South Wales Disability Ability Services Act of 1993, which, among other things, aimed at the integration of persons with disabilities into the community and at the provision of services to enable them to achieve positive outcomes.

The main obstacle preventing further devolution from institutions is lack of money. One senior nurse said that she could move all her clients into the community if sufficient support could be provided. At a practical level, another pointed to wards containing people with severe to profound disabilities and others with serious aggressive behaviour who would be difficult to move. Other facts militating against movement of the developmentally disabled into community facilities were, and still are, a lack of suitable housing and a lack of skilled staff, including psychiatrists, psychologists and other professionals. One optimistic principal nursing manager pointed out that Richmond was only one model of care and that the Department of Ageing

Disability and Homecare (DADHC) had developed different models of accommodation which could provide answers. I am not holding my breath.

The confused and disturbed elderly

During the lifetime of the Richmond Implementation Unit, one of its members, Mr John Haigh, surveyed the 5th Schedule hospital population and came up with a figure of 640 people who were not mentally ill, but suffering from dementia. This led to the development of the CADE (Confused And Disturbed Elderly) units.

The mentally ill

I have already mentioned the more than 100 psychiatric patients successfully moved into supported accommodation during Wootton's three years as head of the Richmond Implementation Unit. In 1990, Professor Gavin Andrews followed up 208 long-term patients who had been discharged over three years and been placed in group homes as a result of Richmond initiatives. He found that only 22 had been re-hospitalised; the rest were living successfully in the community.

Other obstacles

Turning now to factors, apart from lack of money, which impeded the progress of the Richmond initiatives. First, community opposition. It was great to shift people out of institutions but "not in my street thank you. I am not enamoured of the mentally ill and the value of my property will drop"- a common attitude. Secondly, around the time of the Bicentenary celebrations, some boarding houses closed their doors to patients because of greater financial returns from backpackers. In some areas, large boarding houses became valuable property and were sold for a quick profit.

Thirdly, standards: a 1990 circular over the signature of the late Dr Bernie Amos, Director General, dealt with the placement of psychiatric patients in boarding houses and other accommodation. He drew attention to the amended Youth and Community Services Act of 1973, which required minimum physical standards, and good practice in record keeping, management of residents' money and service provision in general. Departmental, regional and area health staff involved in the placement of patients discharged from mental health facilities were instructed not to refer patients to unlicensed places. While it was a good thing to require high standards, boarding houses providing satisfactory services found it uneconomic to meet the physical standards required to remain licensed. They changed clientele to overseas students and backpackers. Their ex-patients migrated to the inner city, to the homeless persons' facilities.

A fourth factor could well have been the 1990 Mental Health Act, which attempts to balance civil liberties with humanitarian treatment. The Act sets down the requirements for people to be involuntarily detained. As well as being mentally ill, there must be a need for admission for the person's own protection from serious physical harm or for the protection of others from serious physical harm. The assessment of such risk is not easy, and whether or not a person is admitted involuntarily depends on the sometimes questionable judgment and experience of admitting personnel. Such a difficult provision in the Act, if not properly handled, could lead to the presence in the community of people suffering from untreated distressing or worrying symptoms of mental illness.

The prison population

Turning now to the *Weekend Australian* and our prison population. I quote: "Leading psychiatrists have admitted that a 20-year policy of treating mental patients in the community has

failed. The psychiatrists are demanding a radical review of mental health care, claiming prisons have replaced asylums as holding centres for the mentally ill.....High on their list of priorities is the re-opening of secure psychiatric wards and an increase in the number of medium- and long-term beds for the mentally ill to take the pressure off prisons, which are ill-equipped to deal with the number of mentally ill inmates." I agree wholeheartedly with my learned colleagues that bed shortages for psychiatric patients are chronic and that some form of institutional care is necessary for a proportion of patients. But, to partly quote Barclay, "not in places like the present Rozelle Hospital where conditions for patients and staff are unacceptable by modern standards."

Regarding the ignorant comment allegedly made by MP Peter Brien, who is quoted as saying the psychiatric hospitals emptied out all their patients after the Richmond Report, I don't need to comment further.

The numbers

To return to Richmond's alleged part in the increase of the prison population, let's look at some statistics. The Australian Institute of Criminology's Trends and Issues paper of 1999 makes the opening statement: "As in many countries in the world, Australia's rate of imprisonment is rising, partially in response to an increased fear of crime in the community. Tougher approaches towards crime are resulting in more severe punishment of offenders, which leads to increase in the size of prison populations." Looking at New South Wales, the Institute states that the imprisonment rate per 100,000 population aged 18 years and over rose from 96.3 in 1982 to 158.7 in 1998. The number of prisoners rose from 3,719 to 7,679 in this 17-year period. One could say that most of this occurred in the post-Richmond years. However, the prison population growth in all other state and territory jurisdictions, uninfluenced by Richmond, suggests that there were other reasons for this rise apart from the Richmond factor.

The Australian Bureau of Statistics Year Book gives a figure of 8,759 prisoners in New South Wales as at 30 June 2002. This is a further rise of 14 per cent since 1998. At 30 June 2004, there were 9,240 prisoners in New South Wales gaols, some 740 of these being periodic detainees. Surely this is not the long arm of Richmond still at work.

Psychiatrically disordered prisoners

The Weekend Australian quote that 74 per cent of prisoners in New South Wales suffered from a psychiatric disorder with almost 10 per cent suffering symptoms of psychosis intrigued me. Being informed that statistics are like bikinis, in that what they reveal is interesting but what they conceal is vital, I attempted to find out what these figures really meant. Firstly, does the term "suffered from" refer to the past or does it describe the current situation in prisons? I shall commence with a quote from the Mental Health Co-ordinating Council 2003 publication dealing with the over-representation of people with mental illness in gaol: "Magistrates and judges have little flexibility within the law to do other than charge people with a mental illness, despite having committed relatively minor crimes, usually as a result of poverty, homelessness and dual diagnosis (the co-morbidity of mental illness, drug and alcohol abuse and/or intellectual disability)".

Perhaps the most useful data I read were in a report by the New South Wales Chief Health Officer based on a Mental Health Assessment Project and the 2001 New South Wales Inmate Health study by Justice Heath. Under the heading 'Mental Disorder' came the following diagnoses: psychosis, affective disorders, anxiety disorders, substance use, personality disorder, neurasthenia.

The prevalence of psychosis amongst the reception and sentenced prisoners was said to be 12 and 5 per cent respectively. Substance use disorders were the most common diagnostic group among both reception and sentenced inmates. They were diagnosed in 66 per cent at reception and 38 per cent of sentenced inmates. Anxiety disorders were the next most common mental disorder, affecting 38 per cent at reception and 33 per cent of sentenced inmates. No statement is made on the prevalence of personality disorder, but from the graph provided, it was close to the prevalence of anxiety disorder.

As compared with Richmond's time, drugs are now a big issue. Opiate and other drug dependency and personality disorders lead to behavioural problems. Such persons are not seriously mentally ill, but they are prison inmates. Though all mental disorders can be distressing, most of the above would not fit into the layman-like category of 'seriously mentally ill'.

To get a better idea of the number of seriously mentally ill in prison, I turned to data from the Mental Health Review Tribunal's Annual Report of 2004. As at 30 June 2004, there were 277 forensic patients in the State, the same day as the New South Wales prison population was 8,500, excluding the 740 periodic detainees. The categories of forensic patients were as follows: not guilty by reason of mental illness 179; fitness 32; limiting term (not a 'sentence', as person is unfit to plead) 16; and transferee 50. Probably some 200 of these 277 forensic patients could be regarded as seriously mentally ill. Even assuming that all 277 forensic patients were seriously mentally ill, it is interesting to see where they were located at the time.

Location	Number	% of prison population
Long Bay Prison Hospital	102	1.2%
Psychiatric hospitals	66	0.8%
Other Corrective Service facilities	34	0.4%
Conditional release in the community	75	0.9%

So if we regarded all 277 forensic patients as being seriously mentally ill and assumed they were all still in prison, which most were not, that would comprise only 3.3 per cent of the prison population. I trust I have given a truer picture of the New South Wales prison population in terms of their mental health.

Conclusions

Some good came out of the truncated and money-starved implementation of the Richmond Report. Considering the outpouring of 340 patients per year from 5th Schedule hospitals prior to Richmond and the reduction to 140 per year since, Richmond can hardly be blamed for emptying out those hospitals. From the facts and figures available, it is also difficult to conclude that his report led to the increase in the prison population.

Returning now to the Weekend Australian's quote that 74 per cent of prisoners in New South Wales suffered from a psychiatric disorder, with almost 10 per cent suffering symptoms of psychosis, I am prepared to accept the fact that about 10 per cent may suffer symptoms of psychosis, but with substance use disorders accounting for 66 per cent of reception and 38 per cent of sentenced inmates, and the large number diagnosed with personality disorders, the quoted figure of 74 per cent suffering from a psychiatric disorder seems pretty fanciful.

My main motivation for undertaking this talk was to correct some misconceptions about the Richmond Report. I hope I have done this. However, I couldn't resist refuting some claims expressed in the Weekend Australian.

References

1. Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled, David Richmond, March 1983
2. Out of Darkness into Light, The Richmond Report, Speech notes, May 2003 Symposium, by David Richmond AO
3. Deinstitutionalisation, Community Mental Health Services and the Future of Rozelle Hospital, William Barclay AM 17 April 2005
4. Help Where Help is Needed: Continuity of Care for People with Chronic Mental Illness, National Health Strategy Issues Paper No.5 Feb. 1993
5. Care of the Seriously Mentally Ill in Australia, Schizophrenia Australia Foundation Survey, 1994
6. Master in Health Administration Thesis, Mental Health in New South Wales, Dr. Graham Edwards, 1975
7. Leading the Way, NSW Health Department publication
8. Australian Bureau of Statistics, Year Book Australia, Crime and Justice, Prisoners in Australia
9. Australian Institute of Criminology, Trends and Issues Publication, Oct. 1999
10. Report of the NSW Chief Health Officer, Prisoner Health, Mental Health, 2001
11. Mental Health Coordinating Council Publication, 2003
12. Beyond Bars, Alternatives to Custody, Fact sheet 9
13. Annual Reports of NSW Department of Health

Acknowledgements

Ken Scott BSW, for internet searches

Mr Andy Robertson, for Leading the Way data

Personal communications: Mrs Jeanette Moss, Mr Michael Sterry, Mr Tim Wootton, Mr John Haigh, Ms Joy Said, Mrs Charlotte Leung, Dr Peter Wurth, Assoc. Professor Michael Levy, Mr Simon Corban, Mr John Ibrahim.

