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Senate Select Committee on Mental Health
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Dear Sir or Madam,

I am grateful for the opportunity to make a submission to the Senate Select Committee on Mental Health. I wish to offer some facts and opinions with particular reference to the first of the terms of reference: “the extent to which the National Mental Health Strategy…(has) achieved its and objectives, and the barriers to progress.”

I write as a psychiatrist with twenty years experience in Western Australia. During that time I have worked in acute care in psychiatric and general hospitals, as the consultant responsible for a rehabilitation unit, as the superintendent of a psychiatric hospital (Heathcote Hospital) during its closure, and as a consultant-liaison psychiatrist. The opinions I express are my own, and not necessarily those of any professional body or health service.

My particular concern is the policy failure in the National Mental Health Strategy to make appropriate provision for the care of patients who are severely and chronically disabled by mental illness.

The large-scale discharge of patients from psychiatric hospitals (deinstitutionalisation) began in the 1950s. The process was initially associated with appropriate optimism concerning the benefits of new treatments and of care in the community. However as early as 1976 a landmark study (Mann and Cree, 1976) in England recorded the emergence of “new long stay patients”, that is, patients who has been admitted to the hospital after the beginning of deinstitutionalisation who subsequently remained in hospital for long periods of time (at least one year, often longer) because of their severe disability.

Subsequent research has confirmed the emergence of this group of patients in Britain, the United States and Australia (McCreadie, 1983; Gudeman and Shore, 1984; Pridmore, 1992; Lelliott, 1994). Furthermore, this research has demonstrated that the prevalence of such patients can be estimated, averaging (across studies) approximately 10 per 100,000 of population. That is,

Western Australia (population 2,000,000) requires, at any one time, about 200 hospital beds for the care of these patients.

The characteristics of these patients have also been quite well established. Gudeman and Shore(1984) described five groups of patients:

(i) Elderly, demented and severely behaviourally disordered
(ii) Intellectually handicapped and psychotic
(iii) Brain-damaged and assaultative
(iv) Schizophrenic and assaultative
(v) Schizophrenic and severely disorganised

The types of patients described by this list are readily recognised by any person who has worked in public mental health services in Australia. These are the patients who are extraordinarily difficult to find placement for in the community, who have very poor quality of life in the community, and who are very likely to be re-admitted to hospital.

These facts were known before the launching of the National Mental Health Strategy in 1992, but were not adequately considered in the framing of that policy. Since that time, under successive National Mental Health Plans, the number of beds dedicated to long stay care has been further drastically reduced. In Western Australia, the current number of dedicated long stay beds is less than 40.

The consequences of this policy failure include:

(i) Chronic and severe blocking of acute hospital beds by patients who cannot be maintained in the community (Pridmore, 1992; Lelliott, 1994)
(ii) Inability to admit patients to acute wards because of this bed-blocking
(iii) Deterioration in the quality of the therapeutic environment in acute wards
(iv) Very poor quality of life for patients with severe disability, whether in or out of hospital.
(v) Demoralisation and severe loss of skills in staff working in the dwindling long-stay rehabilitation services

Based on my experience, it is possible to foster and develop long-stay wards with a rehabilitation focus. Such services should be co-located with acute hospital wards, partly because of the economies of scale involved in providing the necessary support services and partly because of the need to rotate staff for training purposes and to maintain morale when working with a very challenging group of patients. The long stay services should have a rehabilitation focus and have continuing active links with a variety of community services including community residential services; thus all patients should be regarded as potential candidates for community living, although the work necessary to achieve this may take very long periods of time and may not always be successful.

Thank you for considering my views,

Yours sincerely,

Dr Simon Byrne
Friday, 1 April 2005

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