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Foreign reports

Some problems in the management of residents in psychiatric hostels in Western Australia*

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In the wake of legislation overseas, Western Australia promulgated a new Mental Health Act in 1966, paving the way for the establishment of private psychiatric hostels in the community and the discharge from mental hospitals of many chronically ill, long-stay patients.

During 1967, there were 1,493 discharges from the principal asylum in the State, including 300 patients transferred to the new hostels. For the first time the number of patients discharged exceeded the number admitted, which made it possible to reduce the number of beds from 1,500 to 1,100.

Swan Clinic opened on 24 January 1977 and two community mental health nurses were appointed to provide care to hostel residents in our area.

In recent years, the population of hostels had remained relatively steady at about 600 residents, but some 200–250 residents were admitted and discharged each year and these surprisingly large movements in and out needed further investigation. Accordingly it was decided to review the residents in hostels in the Swan area on 30 June 1988 and their movements during the previous year.

Review of private psychiatric hostels in the Swan district

There are eight privately owned psychiatric hostels in the Swan district. There were 213 residents on 30 June 1988, 138 male residents (64.8%) and 75 female (35.2%). More than 75% of residents were aged 50–79 years, which suggested that we were dealing with a population of elderly chronic residents. This was confirmed when the length of stay was considered.

Some 50% of the residents had been in the hostels for more than two years and could therefore be classified as long-stay. Some 80 residents (37.6%) had been in the hostels more than five years; only 35 (16.4%) had been resident less than six months.

As expected, the principal diagnostic groupings were schizophrenic psychoses, organic brain disorder and alcohol or drug abuse, which together accounted for nearly three-quarters of the patients.

During the 12 months prior to 30 June 1988, 86 cases entered the hostels and 71 left; the latter were of particular interest. Two residents left the hostels twice, so the 71 episodes actually refer to 69 residents. The destinations of the 69 residents who left are as follows: died 15; readmitted to Graylands 11; transferred to a nursing home 10; returned to family or the community 20; admitted to a psychiatric unit two; admitted to a general hospital five; other six. Considering the ages and physical disabilities of many of the residents, it is hardly surprising that some died and that some had to be transferred to nursing homes or psychogeriatric units. A comparatively small number was readmitted to Graylands Hospital and in this sense the hostel programme was highly successful. The outcome for those residents who left the hostel system to return to the community was unknown. This represents a serious gap in knowledge as these residents may have returned to living with families and following a pattern of repeated readmissions.

Among the 213 residents were 132 who were directly cared for by Swan Clinic. The other 81 had never been registered with the clinic for a variety of reasons.

The 132 residents were then studied more fully as a sub-group.

Quality of care

From the beginning of 1987, an attempt was made to institute regular reviews of all patients under the care of the clinic and prepare individual care plans. Follow-up was taken to be satisfactory if the resident had been reviewed at least once every six months on average.

In summary, follow-up was only undertaken sufficiently often for 95 of the 132 registered residents, indicating that much tighter administration of the programme was required.

Based on a paper read at the Annual Meeting of the Social and Cultural Section of the Royal Australian and New Zealand College of Psychiatrists in Darwin, September 1990.

More than half the residents were taking either fluphenazine decanoate, given by injection or thioridazine, which was often given as a suspension, reflecting some difficulties in ensuring patient compliance.

The residents suffered from a wide variety of physical complaints. Epilepsy was the most common, affecting 14 residents. Other disorders included: diabetes (5), chronic bronchitis (4), chronic obstructive airways disease (4), peptic ulcer (3), asthma (3), and coronary artery disease (3). Only 56 residents had no physical disorder and the importance of close liaison with the general practitioner in planning overall management was abundantly clear.

Quality of life

Occupational therapy records were examined for the months of June and July 1988, i.e. one month either side of the survey date. There were wide variations in the amount of use made, but using operationally defined criteria 79 (63.7%) of the 124 residents who made use of the facilities did so on a regular basis, 45 (36.3%) on an occasional basis.

Nevertheless, there must be concern about the 89 residents who made no use of the facilities.

Discussion

Accommodating the chronic mentally ill in privately owned community hostels follows the pattern set in the USA, where a Californian study showed that about one-third of all the long-term psychotic patients in the community were placed in board and care homes (Lamb, 1970). In many such homes the passivity, inactivity, and lack of spontaneity among the residents was striking. As a group, the residents were characterised by an overwhelming dependency. It was considered an illusion that these residents were "in the community" at all, and that it would be more realistic to regard them as members of a subsociety (Lamb & Goertzel, 1971).

Many of these drawbacks were becoming evident in our own practice and it is convenient to consider them under four headings:

The myth of rehabilitation

Part of the rationale for discharging chronically ill mental patients from hospital was the assertion that they would be able to manage themselves better and achieve a normal or nearly normal level of functioning in the community. There is little evidence that this can be achieved (Howard & Kontny, 1982) and for many of the elderly the goal of independent living is meaningless. In the past, the discouragement and frustration of pursuing unrealistic goals have been experienced by all workers in the field. Nevertheless, there would seem to be scope for social workers to expand their professional roles by teaching residents the skills required to take advantage of their opportunities.

The myth of reintegration

Another part of the rationale for discharging patients from mental hospitals was that by reintegrating them into the community the dehumanising process of institutionalisation could be avoided. This assumption was based on very vague notions of what constitutes a relevant community. There has been no systematic analysis of the concept of community but the assumption has often been made that it is synonymous with catchment area, disregarding separate ethnic and cultural boundaries.

The myth of monetary savings

The spiralling costs of hospital care made community programmes appear financially attractive, but the costs of hospital care remain high unless the hospital is actually closed and the land sold. In the initial stages at least, there is likely to be an increased cost if adequate community resources are developed in parallel with the reduction of hospital facilities. In fact, hospital costs may also increase as the number of staff has to be increased to deal with the increasing number of admissions.

A careful cost-benefit analysis, including hidden costs in the USA suggested that, overall, it costs about 10% more to treat a patient in the community than in hospital (Weisbrod *et al*, 1980).

The myth of continuity of care

Community mental health programmes set great store by "continuity of care", which is to say that patients should be able to receive the services they need when they need them regardless of which particular agency is delivering the service. In practice, there is little sense of reward or accomplishment for professional staff because long-term patients often fail to keep regular appointments, become non-compliant with medication and make little headway with psychotherapy. This lack of motivation frequently leads to disorganisation and fragmentation of care.

There may well be opportunities for community mental health nurses, who have the required skills (Buchan & Smith, 1989) to expand their roles as case managers.

Conclusions

The care of residents in hostels was clearly far from satisfactory, but it was possible to frame a number of recommendations as follows. There should be:

(a) improvement in administration to ensure that residents are reviewed regularly and care plans are updated

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(b) re-orientation of occupational therapy services away from rehabilitation and towards improvement in quality of life
(c) expansion of the roles of social workers to improve social skills among residents and monitor quality of life indices
(d) expansion in the role of community mental health nurses as case managers
(e) improvement in communication with hospitals in the preparation of discharge plans
(f) investigation of the outcome for residents who leave the hostel system
(g) a study of ways to improve compliance with medication.

References

BUCHAN, T. & SMITH, R. (1989) Nursing process in community psychiatric nursing. *Australian Journal of Advanced Nursing*, **6**, 5–11.

HOWAT, J. G. M. & KONTNY, E. L. (1982) The outcome for discharged Nottingham long-stay in-patients. *British Journal of Psychiatry*, **141**, 590–594.

LAMB, R. (1970) The new asylums in the community. *Archives of General Psychiatry*, **36**, 129–134.

—— & GOERTZEL, V. (1971) Discharged mental patients – are they really in the community? *Archives of General Psychiatry*, **24**, 29–34.

WEISBROD, B. A., TEST, M. A. & STEIN, L. I. (1980) Alternatives to mental hospital treatment II. Economic benefit – cost analysis. *Archives of General Psychiatry*, **37**, 400–405.

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New mental health legislation in Japan

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In Japan the Mentally Disordered Persons Supervision and Protection Law (1901) and the Mental Hospital Law (1919) used to be the main laws for mentally disordered people. Subsequently, the Mental Hygiene Law came into force in 1950 but was criticised as it had restrained admitted patients and the provisions for procedures for the release of patients were inadequate. The purpose of the old law was to give medical treatment and custody to mentally disordered persons and to maintain and improve the mental health of the nation. In the revised law, enacted in July 1988, acceleration of social rehabilitation of mentally disordered persons and promotion of their well-being were added.

The conflict between the legal model, intended to restrict legally the right of discretion of physicians, and the medical model has become active in various countries. From about 1965 there was an international trend emphasising the legal model in the revision of the Mental Hygiene Law which also affected revision of the law in Japan. The Mental Health Law of Japan was established by incorporating the legal model into the medical model and can be described as follows:

General provisions

Purpose of the Law

The name of the law was changed from the Mental Hygiene Law to the Mental Health Law, "the purpose of this law is to provide mentally disordered persons, etc. with medical care and custody, as well as to promote their social rehabilitation, and to make efforts toward the prevention of mental disorders, and the maintenance and improvement of the mental health of other people, in an attempt to advance the general well-being of mentally disordered persons, etc. and to improve the mental health of the nation".

Duties of the National, Prefectural and Local Governments

It is stated that "the National, Prefectural and Local Governments shall endeavour to enable mentally