A DYING SHAME

Name: Ben Chapman **Age:** 19
Lived: Central Coast, NSW
Probable psychotic episode leading to suicide attempt
Admitted to psych unit, Gosford Hospital
Discharged from hospital within 48 hours
Committed suicide less than 12 hours later

Ben Chapman's death is the story of a suddenly troubled boy, an overcrowded psychiatric ward, inexperienced staff, too-early discharge, no communication with family, and no follow-up. Every year hundreds of people die such preventable deaths – fatalities in a social experiment gone wrong. And officially covered up.

BY HALL GREENLAND

REFORM OF THE MENTAL HEALTH system in Australia in the 1980s and 1990s hit all the hot buttons. "Human rights". "Community care". "End of the stigma". "Self-reliance". "More normal lives". There were to be no more men in white coats to whisk away the family embarrassment in the middle of the night. No more lingering, living deaths behind high walls. No more padded cells. No more people strapped to benches and convulsed with electricity. You could throw away the straitjackets; the nightmare of mental illness was over. Ken Kesey's Nurse Ratched was out of a job. People with mental illness were to walk free.

They walked all right, many of them to premature deaths. During that short march to the promised psychiatric paradise, the annual number of fatalities has doubled. In the larger states, it may have quadrupled.

About 400 mentally ill patients throughout Australia – most of them aged in their 20s and 30s – will commit suicide this year because the places that once treated them have been closed or diminished. They are being turned away and sent to their deaths.

ILLUSTRATION DARON PARTON

Duty to Care, a landmark West Australian study that recorded this growing toll, introduced the concept of "excess deaths".

Some of these excess deaths are of other people. Brutally put, increasing numbers of those turned away are going home to kill. Murders by mentally disordered persons (to use the jargon of criminologists) – although much rarer than suicides – are running at three a month, having nearly doubled from 20 victims in 2000-'01 to 36 in 2001-'02.

If there is any good news – and a cynic may have predicted this – it is that the rising homicide toll, rather than the suicides, appears to have prompted a belated change of heart by authorities – in NSW, at least. Following an investigation into a cluster of mental health homicides in the state, undertaken by a man who can only be described as NSW Health's confidential agent, an unheralded, secret inquiry has been set up.

The absence of fanfare is true to form. For almost a decade there has been an official cover-up *(see story on page 28)* of the death toll in NSW and a remarkable media reticence about criticising an experiment that has had such a high cost in human terms. One head-office apparatchik, whose job is to secretly add up the death figures, admits: "If it had been SARS [deaths], there would have been an outcry."

> **AS MANY AS**
> **2-3%**
> of Australians suffer from "schizophrenia, major affective disorder, eating and obsessive compulsive disorders, personality and a number of other conditions that are sometimes referred to as 'serious mental illness' ". *

To be fair, a journalist with *The Sydney Morning Herald* who tried in 2001 to use freedom-of-information laws to force NSW Health to release the death toll figures was refused on the grounds that "it would unreasonably divert the department's resources to attempt to process your application".

One of the new mental health system's critics (you might have labelled him alarmist if you did not know the numbers) cites Freud's contention that two forces lie at the

root of human existence – the life force and the death force, or Eros and Thanatos, to use the ancient Greek concepts – and argues that the second has been let loose.

When you talk to the loved ones of the victims, they have a tendency to blame the doctors – and the coroners' findings often echo this. How could health professionals have let these sick people out when the families and friends knew these patients would try to kill themselves or others?

Unavoidable, all-too-human error does play its part and Dr Bill Barclay, probably Australia's most experienced forensic psychiatrist, argues convincingly that not all these deaths are preventable. "Even the best psychiatrists make mistakes in risk assessment," he says. "And we all know that even if we hold people for treatment, we may only be delaying their suicide." But that delay can and does offer a window of opportunity for successful treatment, as Barclay concedes.

Trouble is, as we shall see, the state of the system and its underlying philosophy do not encourage such delays – in fact, they discourage it. Even with improvements in the clinical practice of hospital psychiatrists – which family members without exception cry out for – the death toll will persist if the built-in bias of discharging unrecovered and dangerously ill people is not ended.

Authorities have replies for all these arguments. Their main one – the reefer madness defence, if you like – is that the new libertarian system has been overwhelmed by a wave of drug-induced or drug-exacerbated madness. Professor Beverley Raphael, director of the NSW Centre for Mental Health, said in June that the numbers of people requiring psychiatric treatment fronting at hospital emergency departments had doubled in the past decade. She put it down to drugs. Barclay also says that drug addiction has added a new dimension to mental health care. "When I left the system in the late 1980s, this problem did not exist," he says.

Yet it remains true that many of the deaths are not related to drug addiction.

While the silence of governments, the obfuscation of health authorities and media deafness have largely kept this new category of deaths out of the public arena, coroners have heard the screams. Take one case off the top of a pile of findings from coroners in NSW and Victoria. Significantly, it does not involve illicit drugs.

NEEDLESS TRAGEDY
George and Chris Chapman with a picture of their son Ben. "[Medical staff] told us nothing," Chris laments.

Ben Chapman was 19, a tall, good-looking man who worked part-time in a supermarket and was scoring top marks in his TAFE course. Like his mates, he skated and had studs in all the wrong places. The only clouds on his parents' horizons were that he had lately become introverted, brooding and played rap music so loud that it disturbed the neighbours. Then in the early hours of the second Monday in December 2002, Ben took the family car and tried to drive over a cliff. When that failed, he drove headlong into the side of a house. Still alive, and charged with all the energy a psychotic episode produces, he fled into nearby bushland.

Ben's family and mates joined police in the manhunt that followed. It wasn't until some hours later that he was finally captured – his mates had caught him earlier but he had managed to break free. Half-dressed, bloodied and wild-eyed, he was admitted to Mandala, the psychiatric unit at Gosford hospital on the NSW Central Coast.

Less than 48 hours later, he was discharged – by a doctor with "only" four months' experience in the job, according to the coroner, although a more senior doctor assented to this discharge. Ben was lucky to stay that long: his mother and Ben were told on his second night he would have to give up his bed and be sent home if a more pressing case presented. His father brought him home the next day. Ben waited until the family was asleep that evening, then walked out of the house to a nearby railway bridge and threw himself in front of a train. Police took fingerprints from his bedroom to match the remains.

Ben's mother and father recounted these details from their NSW Central Coast project home at Blue Haven, a typical subdivision circling regional centres in the state. Chapman's father George paces and hovers at the far end of the living room, breaking his silence only after his wife Chris has told the story of their son's final days. "Why didn't they tell us that the medication takes at least two weeks to start working?" he asks from the far corner.

"They told us nothing," Chris adds, "Just sent Ben home as though he had a Band-Aid on him. Even when my daughter had the cast taken off her broken arm, they said don't go yet until you have talked to the doctor. We didn't even get that."

The day Ben came home, George arranged with his employer to take four weeks' leave to care for his son. But that first night Ben took his life. Still broken with grief, George tries to understand what happened. Chris is in no doubt about what should have happened. "They should have kept him two or three weeks until they were sure he was all right. I know he would have come good."

But such treatment is rarely available or possible today. In the 1980s, the doctrine of "least-restrictive care environment" was written into mental health acts in all states and the wholesale closure of psychiatric hospitals followed. Some of the lost beds were transferred to general hospitals as new psychiatric annexes were established; these are invariably crowded and unwelcoming. Community care was the new panacea, yet it was a promised land never reached. As a pathologist who gave evidence to the NSW Upper House select committee on mental health last year put it: "Community care too often means no care."

Yet the instincts of Ben Chapman's mother about the hospital care her son should have had are correct. The anti-depressants prescribed for Ben not only take time to take effect, in some cases, they don't work at all; in others, they can worsen a patient's condition before they kick in. Barclay says they can take two to four weeks to work. The uncertainty of medication is one reason why the critics of de-institutionalisation advocate a return to longer stays and closer observation. The *Duty to Care* study in WA noted that, in acute cases, the average length of stay has been reduced from five days to three.

Coroner Michael Morahan made these points in his finding on Chapman's death: "Staff were over-anxious to discharge Ben due to the perennial shortage of beds at Mandala and this is one of the many cases which highlight government neglect in the area of mental health facilities."

Like Chapman, half of mental health

THE COVER-UP HALL GREENLAND

GADFLY Jean Lennane indicts economic and political correctness

LEFT: DEAN SEWELL; ABOVE: KYLIE MELINDA SMITH

The silent treatment

The least-restrictive care policy for patients with mental illness is obviously flawed, as the damaging correlation between deaths and lack of beds shows. An official cone of silence is not helping matters.

For Sydney psychiatrist Jean Lennane, the long silence on the mounting mental health death toll is explained by an unholy united front. "People with a mental illness have been caught in a deadly pincer movement from the right and the left," she says when talking about the closure of psychiatric hospitals in the past 15 years and the doctrine of least-restrictive care. "The right believes in curbing public spending regardless of the human cost, and the left believes in promoting freedom even if it kills you."

There is no doubt that least-restrictive care is also least-expensive care. Ruth Vine, the deputy chief psychiatrist in Victoria, says the cost of an acute bed in a hospital is $380 a day, compared with $200 a day for a bed in a 24-hour staffed community residential unit.

Between World War II and 1980, the numbers in psychiatric hospitals fell from 400 per 100,000 to fewer than 100. Nevertheless, the 1980s reformers further accelerated the cuts, halving beds nationwide. As for the fatal effects of this revolution, the mental health authorities have been secretly collecting the figures, counting the bodies. Each year, hospitals and area health services tot up the death toll. They have special forms. In NSW, they are called "Mental health client death report forms", and in Victoria, "Notifications of reportable deaths including suicides in the public mental health service". These macabre pieces of paper, dry collections of statistics steeped in pain and tragedy, have been flowing into capital city head offices for more than a decade. Requests for these figures were rebuffed in NSW and Victoria: the collected figures were "unreliable", "unavailable" and yet to be checked against coronial records.

There are other reasons for the official silence, which Gavin Stewart, evaluations manager at the NSW Centre for Mental Health, spells out: media reporting of suicides leads to a copycat surge in suicides. "A stack of studies confirm this," he says. Lennane, chief gadfly from NAPP, counters: "This may be true of celebrity suicides but the official suppression of these figures for a decade has led to hundreds of preventable suicides. The real danger is in the censorship of the death toll. That's what kills."

Only in Western Australia have the death toll figures been published. A University of WA research team found annual deaths from suicide among mental health patients doubled from 1980 to 1998. The climb was sharpest in the early 1980s at the beginning of the bed closures and accelerated again in the late 1990s when there was another round of bed reductions.

In NSW, there appears to have been an even more dramatic increase in suicides of the mentally ill. A research paper covering 1993-1995 gave an average five or six deaths a month from suicide by mental health patients. Five years later, the toll for 1999 and 2000 was 14 to 15 a month, according to a leaked draft confidential memo from NSW Health. Lennane produces 1989 figures that show 2 to 3 deaths a month.

While there is an official argument that the pre-1995 figures underestimated the death toll, the point made in 1997 by New Zealand nurse Peter Neame (and echoed by the WA study) appears to be inescapable: "You cannot close places of safety for the mentally ill – psychiatric hospitals – without a subsequent rise in the suicide rate."

STATE SPENDING

Annual spending on mental health per head of population varies greatly between states. In 2000, the figures were: *

State	Spending
WA	$96
SA	$86
Vic	$84.5
Tas	$80
Qld	$80
NSW	$77

BEVERLEY RAPHAEL Concerned about the death toll but won't release the figures – yet

Juggling the figures

While numbers are hard to come by, more beds for the mentally ill are being promised, and even provided. But where are the staff to manage them?

Beverley Raphael, the friendly, squeaky-voiced professor who heads up the Centre for Mental Health in NSW Health, is defensive at first. She begins by justifying the refusal to release death toll figures – they are "not reliable", have yet to be "processed", "finally collated", "fully analysed", and matched with coronial figures. They will be made publicly available next year, she promises.

Informed the delay could appear astonishing given the seriousness of the situation, Raphael admits: "It certainly sounds like it should have happened earlier ... it was certainly on the agenda." She is equally ill at ease when asked for figures about her claims of increasing numbers of mental health staff. Her centre does not have workforce data but this is "another data-collection initiative we are putting in place".

About midway through the interview, Raphael reveals she shares concerns about the death toll and claims credit for the Sentinel Events Review Committee. "It was my push that has put this absolutely independent committee into place. It has been my clear belief since I arrived in this position [in 1996] that we need more beds." The NSW government has listened to her, she says, delivering funds for 300 more beds in recent years.

Raphael is certainly aware of the bed shortage. As she told the NSW select committee into mental health, when giving evidence on August 12 last year: "As occurred in the middle of last night, I am rung to find a bed when one is needed."

Raphael reports some progress, claiming the mental health suicide toll is falling. Victoria's deputy chief psychiatrist Ruth Vine makes virtually the same claim for her state. But the critics claim otherwise. When *Four Corners* put the Raphael claim to former National Association of Practising Psychiatrists president Rachel Falk last year, Falk dismissed it as "patently nonsense. Why would they be decreasing when the system is demonstrably getting worse and worse?"

It is of course easier and quicker to demolish a system than to rebuild it. Beds are being promised, and even built, but there is no staff. Dr Alex Campbell, acting head of the Central Coast Area Health Service in NSW, told the Ben Chapman inquest in June *(see main story)* that, while there were plans to treble the number of beds to 75, the department could not even staff the existing 25 beds.

Falk says: "The working conditions are so poor – the staff dissatisfaction, burnout, incapacity to actually do what they want to do with patients, help them, treat them adequately – people don't want to go into the system." – *HALL GREENLAND*

suicides happen within 48 hours of discharge. Yet it has been known for at least a decade that the suicide rate in the immediate period after discharge is 100 times the rate for the general population; for patients with depression, it is up to 500 times. A 1995 research paper, published by NSW Health itself, listed among the reasons for this "the fact that the patient may not be fully recovered".

Stories of sending vulnerable, unrecovered patients back into the world are legion. Just last month a neighbour told me this story, which checked out. A country NSW woman (call her Jan) with a long record of mental illness had recently attempted suicide. She went to hospital where she tried to kill herself again but was nevertheless discharged two days later and put on a bus alone to go home to a vacant house. (Her sister had been at the hospital half an hour before the discharge but was told it would not happen until the next day.)

The next morning, unable to raise Jan, her sister rang a community mental health worker soon after 9am to ask for an urgent visit, only to be told not to worry because Jan had been instructed to ring for an appointment. Jan's sister then drove the two hours from Sydney to find Jan dead from an overdose. On Jan's answer machine was a message from the health worker, left at 9.40am, reminding Jan to ring about her appointment. Understandably, Jan's sister is not just grief-stricken but angry.

If it can be put this way, Ben and Jan were lucky to be even admitted to a hospital psychiatric ward. Take the case of Bob Robinson (not his real name because his family was divided over the use of it). This 29-year-old, suffering from schizophrenia, attempted suicide by jumping from the first-floor balcony of his family home in the Melbourne upper-middle-class suburb of Kew. Taken to hospital by his mother "Joan", Bob convinced "the community assessment team" that he was OK. Despite his mother's misgivings ("Look, they treated me like an idiot," she recalls in her strong, educated voice), he was sent home.

That night she suspected he had overdosed – she found emptied medication packets in the bathroom – and rang the hospital again, only to be told to monitor his condition and ring again in the morning. Later, desperately worried, she tried her brother (a doctor in Brisbane) but he was at a dinner party and she didn't want to bother him. It was a long watchful night: about 2am, and then a few hours later, she checked. When she finally woke at 7.30am after a night of fitful sleep, Bob was scarcely breathing and died on the way to hospital. Only now is Robinson's mother coming to terms with the death of her youngest son. "I was off my head for 18 months, crying all the time." She still has not forgiven the hospital and confesses she has not been able to decide on a headstone for the grave. "I just haven't had the strength." Like Chris Chapman, Joan Robinson says her son should have been kept in hospital. "You know it is not certain that he even suicided. He told me he just wanted to get rid of the voices."

This "overanxious to discharge" habit was at the centre of recent media furore over a man who sued NSW Health and won $300,000 in damages. Under the influence of alcohol and marijuana, Kevin Presland had a major psychotic episode (he tried to throttle a three-year-old and had to be subdued with a cricket bat) but was released from hospital care the next day despite the objections of his brother. He went back to the brother's house and later that day murdered the brother's fiancee. Taxed with this overanxiety to release, a hospital psychiatrist echoed official policy: "I cannot go and jump on everyone and put everyone in the wards because yesterday he was suicidal ... or murderous."

But staff are aware that they are discharging people who are still possibly suicidal or murderous. Their union, the Salaried Medical Officers Federation, told last year's NSW Upper House inquiry into mental health services: "It is often the case that patients are discharged from hospital in a state of health which 10 years ago would have resulted in their admission to hospital." The National Association of Practising Psychiatrists made the same point: "Early discharge of patients in the acute phase of psychotic illness is now routine."

It is easy to see why. The doctrine of least-restrictive care has led to fewer and fewer beds, and the consequent overcrowding, understaffing and overwork prompt staff to discharge too soon.

How this combination can work is illustrated in the case of Janet Le Good's 28-year-old daughter Kathlyn. She was discharged from a northern Melbourne hospital psychiatric unit and hanged herself a month later (there was no follow-up supervision by community mental health staff). Janet admits that her daughter wanted to get out. "When my daughter saw the people roaming around in that psychiatric ward, it scared the crapola out of her. All types were jammed in there together. It was like putting a child recovering from having her tonsils out in with a lot of old people dying of throat cancer." She adds that the doctor who rebuffed her pleas to hold her daughter longer "had black circles under her eyes; she had probably just worked a 36-hour shift".

Proper hospital care – if it were available – is the safe alternative. As the WA study *Duty to Care* (documenting the fate of every mental health patient in the state between 1980 and 1998) pointed out: "The suicide rate was lowest during inpatient care and was comparable to the suicide rate of the general population." A Victorian study of mental health suicides between 1989 and 1994 found only 13 inpatient suicides in the total of 619.

FAIRFAX PHOTOS

JULIAN KINGMA; COURTESY OF JANET LE GOOD

PREMATURE DISCHARGE
Janet Le Good, above, claims mental health staff "failed" her daughter Kathlyn, top

IN VICTORIA

89%

of people hospitalised with a mental illness said they were discharged while still acutely unwell. **

The factors that lead to preventable patient suicides are also behind the homicides, according to Bill Barclay. He should know, for he is NSW Health's confidential private investigator. Probably the foremost authority on the public mental health system, Barclay was chief psychiatrist in the NSW health system from 1966 to 1977, then embarked on a late career as an expert witness in cases of murder by mentally disordered people. "I helped develop the defence of substantial impairment," he says. When a cluster of nine homicides by recently discharged psychiatric patients occurred in NSW in 2001, the NSW Centre for Mental Health sent for Barclay.

He cannot divulge details of his report – he suggests I try an FOI approach – but in the recent Attia murder-suicide case in NSW part of his secret report was subpoenaed by the coroner. Violent and suicidal, Hossam Attia tried to kill himself by driving his car into a wall. After being admitted to hospital, he was assessed by two psychiatrists as being at high risk of doing harm to himself and his family, and was recommended for hospital treatment. Two days later, another two psychiatrists (without consultation with Hossam's wife or their colleagues) gave him a prescription for anti-depressants and let him loose. He went home and shot his wife, then himself. Their three children were in the house at the time. Asked later by the coroner why they discharged him, the doctors replied: "Risks of suicide and harm to others were considered high. However, community management was considered the least restrictive option."

THE HIPPOCRATIC OATH

Whatever the macro defects of the system, the parents and wives of victims, even the coroners, often blame the staff. "I still can't bring myself to forgive the hospital and the triage nurse and the crisis assessment team that sent Bob home," Joan Robinson says. Coroner Michael Morahan was trenchant about the psychiatrists at Mandala who discharged Ben Chapman, describing their evidence as "talking in circles". He found: "Medical justice does not appear to have been done." NSW deputy chief coroner Jacqueline Milledge came to the same conclusion in the Attia case.

Diane Oakes is still critical of staff at Manly Hospital in Sydney. When Oakes accompanied her 27-year-old son Matthew (who had a history of depression, drug overdoses and suicide attempts) to Manly Hospital after

police found him sitting in his sealed car with a hose connected to the exhaust, the first psychiatrist she saw refused to admit him. "He said that Matthew told him he was just experimenting with car exhaust fumes – and he believed him. If I hadn't burst into tears and refused to leave, they would not have admitted Matthew."

Later that night, she rang the staff to say her son had phoned home from the ward to say goodbye and she begged for a close watch on him. But it wasn't close enough; he committed suicide early the next morning.

Oakes is one of those parents who continue to campaign for mental health reform. Graeme Bond in Victoria has been at it for 10 years. After repeated suicide attempts, his son Jason was discharged three times in eight days before he eventually succeeded in killing himself. Bond sees the problem as the failure of staff to observe the high-sounding treatment protocols on mental illness and suicide that every state has in fact adopted. Last year, the Victorian auditor-general found that these protocols were more frequently breached than honoured.

Janet Le Good puts it simply: staff at the hospital and community mental health workers "failed my daughter". Even New Zealand-born author and forensic nurse Peter Neame, who advocates a return to the old stand-alone psychiatric hospitals, surprises me when I advance the alibi that staff discharge because of the pressure on beds.

"No, the staff should treat them properly no matter what the conditions," Neame says. "If people need treatment, nurses and registrars should just keep them there, even if it means beds in the corridors or mattresses on the floor."

But it is Kathy Heyes, the quietly spoken widow of Geoffrey Heyes, who absconded from the Missenden unit at Sydney's Royal Prince Alfred Hospital and jumped from Anzac Bridge, who makes the point about staff culpability most persuasively. She recounts her own struggle to have Geoffrey admitted: he woke her at 3am one morning to give her a suicide note but, even though he was suffering from psychosis as well as deep depression ("the television was telling him to kill himself"), it took her until 7pm that night to get him admitted. A crisis team came in the morning but declined to act. When the hospital did agree to admit him after hours of waiting, she was not consulted during his assessment. She is convinced staff were too lax in their supervision, allowing him to abscond and go to his death.

The only extenuating circumstance she will allow them – and Chris Chapman has mentioned this, too – is the bedlam and circus antics that can reign in hospital psychiatric wards. "All kinds of cases are bunched together in the unit, including the chronic cases, the regulars who roam around disrupting and claiming a lot of attention," she says.

"MATTHEW TOLD THE PSYCHIATRIST HE WAS EXPERIMENTING WITH CAR EXHAUST FUMES – AND HE BELIEVED HIM"

DIANE OAKES

SUICIDAL Diane Oakes, above, had to battle to get her son Matthew, left, admitted to care despite his poor psychiatric history

IN VICTORIA

65%

of psychiatric admissions rated as 'urgent' did not receive a face-to-face assessment from a mental health clinician within 24 hours. **

This memory softens but does not alter her judgment: the more-beds position won't wash. "Every service could do with more funding. That's just avoiding the problem," she says. "The assessment procedures are what is crucial and staff have to remember they have a duty to care. Hospitals are there to save lives – and I'm afraid that, as far as people with life-threatening psychiatric conditions are concerned, they are not."

ALIBIS AND DEFENDERS

There are, on the other hand, defenders of the system. Their argument is essentially that the suicide and homicide death toll is the unfortunate price we pay for freedom and the happiness of the greater number. Victoria's deputy chief psychiatrist Ruth Vine, for example, sees the suicide toll as "the downside" of an approach that is basically heading in the right direction.

Vine sees the call for more beds and longer stays as "simplistic". She believes the prime emphasis should be on active support in the community after discharge. Whether that would have saved people such as Ben Chapman or Bob Robinson is a moot point; families do have to sleep and cannot run shifts like a hospital can. Nor are they in a position to deal with florid (angry and violent) psychosis.

Although Vine acknowledges the number of beds is under pressure in Victoria, she also points out that a relatively low percentage of discharged patients actually commit suicide or murder, and that picking the future dead (and killers for that matter) among thousands of cases each year is well nigh impossible.

But the mental health authorities in NSW are not in a position to rely on the upbeat Vine position. The death toll is too

COURTESY OF DIANE OAKES; KYLIE MELINDA SMITH

high. They acknowledge that gadflies such as Sydney psychiatrist Jean Lennane *(see story on page 26)*, and the small band of psychiatrists and parents who have been campaigning for reform, have a point.

Without fanfare, NSW Health (the Centre for Mental Health is its policy and advisory unit) has set up the Sentinel Events Review Committee. Its brief is to come up with recommendations to cut the death toll among patients of the mental health system.

The secrecy surrounding this committee makes Lennane wary. Nearly half the committee's members are either employed or funded by NSW Health and the committee meets at NSW Health's head office. Members have been literally sworn to secrecy; each has had to sign a confidentiality agreement and are warned that they face a fine of $10,000 or six months in jail if they break it.

This is enough to deter members of the committee from speaking on the record. Its chairman, Professor Peter Baume, did not respond to messages from *The Bulletin* on his answering machine.

The NSW death-toll committee is what is known as "a standing committee" – like the committees that exist for child deaths and anaesthesia deaths in most states. This is the first for mental health in Australia and has long been advocated by people such as Lennane. "Death, after all, is the ultimate failure of a system of treatment," she says.

The committee, set up in August last year, was recommended by the Barclay report on the bunch of 2001 homicides. It is expected to issue its first report in February next year.

Among its 15 members is a carer representative, Jenny Mackellin. Her presence is crucial because one of the most common threads in the tragedies of mental health deaths is that family members' opinions were not heeded. Invariably they object to the rush to discharge or warn about what could happen, and almost invariably they are ignored, with deadly consequences.

REEFER MADNESS

The de-institutionalisers blame drugs for their problems. They argue that drug addiction either makes those already mentally ill worse, or it arouses an illness that would otherwise lie dormant.

Mentally ill people are now in a position to take recreational drugs like anyone else. And they do. Massively. Most people with serious mental illness use – unadulterated or in cocktails – alcohol, marijuana, amphetamines and heroin. It's not as though they are in constant party mode; it is more like "self-medication", a search for consolation, escape and mood improvement.

Observers can and do argue over this phenomenon – some blaming the drugs (especially marijuana) for causing or exacerbating illness. Others, more controversially, see self-medication as a means of increasing the level of serotonin in the brain in much the same way as modern anti-depressant and anti-psychotic drugs do. (Low levels of serotonin are associated with acute mental illness; therefore, upping the level is viewed as a way of alleviating symptoms and increasing periods of normality and pleasure.)

However, people in hospital emergency or psychiatric wards see only one side of the story: a wave of drug abusers and disturbed people coming through their doors. And after they have gone back out the doors, it's the coroners' turn to see the same people with dual-diagnosis problems, or by that stage, "co-morbidity factors".

It's not just a question of increased numbers. There are also the problems of diagnosis. When a mentally disturbed person turns up at a hospital under the influence of drugs such as alcohol and marijuana, the psychiatrist or nurse has to decide if their condition is drug-induced or if there is an underlying mental illness that has been exacerbated by drugs.

While the layperson may think it doesn't matter much – the person is still surely a suitable case for treatment – the "reforms" of the 1980s separated mental health and drug-addiction services. The first is only interested in cases of underlying sickness and the second in drug-induced problems. As it is often unclear what the correct diagnosis is, those in need can be shunted back and forth until they fall between two stools – sometimes to their death.

Matthew Oakes is a classic example of dual diagnosis: in and out of hospital psychiatric units, but as a heavy marijuana user he did try a month before his suicide to be admitted to a detox program. He rang the program every day for four weeks to no avail. There were never any spare beds. Soon after, he began his final downward spiral.

The situation is no different or better elsewhere. Three years ago, Victorian deputy state coroner Iain West, delivering his findings on a clutch of drug and mental illness-related suicides on suburban railway lines in Melbourne, recommended that "consideration be given to establishing a specialist dual-diagnosis withdrawal unit and long-term rehabilitation unit, which has the capacity to accept involuntary admissions. Such a clinic would need to be staffed by clinicians educated and experienced in both mental health and substance abuse management."

This was not the first of such recommendations but they have not been acted upon. "We now have four dual-diagnosis teams," Ruth Vine says, "but no beds."

Whatever way you look at the death toll, the recurring problem is that there are just not enough hospital places. Even if the brave new world of mental health has been ambushed by history – by a pandemic of reefer madness – the de-institutionalisation push has clearly gone too far. Active, collaborative, longer-stay treatment in well-resourced hospital settings needs to be back on the agenda.

At the end of her interview, Raphael appeals for a positive story. "Mental health needs all the friends it can get," she says. It certainly does. But people with mental illness need them more. The crisis they face was captured last year in an exchange between Dr Brian Pezzuti, chair of the NSW select committee into mental health, and a government pathologist giving (unauthorised) evidence about the problem of too-rapid discharge. Pezzuti was looking for confirmation that the witness saw the problem in terms of too few beds, and he got it – in spades.

Chair: "There is too much pressure on hospital beds, is there not?"

Dr Ella Sugo: "Yes, but I guess there is going to be pressure in the graveyard if it continues." ●

AVAILABLE BEDS

Reduction in hospital beds in public sector between 1992 and 2000: *

8000 to 6000

Increase in hospital beds in private sector between 1992 and 2000: *

1300 to 1600

LONG-TERM CARE

2200

long-stay beds eliminated between 1992 and 2000. *

ACUTE BEDS

20 PER 100,000

is the number of acute beds available for people who are a threat to themselves or others, a figure that remained static from 1992 to 2000. *

*** Source: National Mental Health Report 2002**

**** Source: Victorian Attorney-General's Report 2002**

Care to comment? Write to Letters, *The Bulletin*, GPO Box 3957, Sydney, NSW 1028; fax (02) 9267 4359; or email *bulletinletters@acp.com.au*