Pairs

Mr Riebeling	Mr Tubby
Ms Anwyl	Mr Baker

Question thus negatived.

DEATHS AND SUICIDES AT GRAYLANDS HOSPITAL

Motion

MS McHALE (Thornlie) [6.10 pm]: I move -

> That this House notes with alarm the distressing report on deaths and suicides at Graylands Hospital and calls upon the Government to -
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> (a) respond to the call for an inquiry into the matters raised by the families of patients who have tragically suicided;
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> (b) adequately fund mental health services to ensure comprehensive community services are available and that in-patient services are appropriately funded; and
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> (c) begin to take seriously the needs of people affected by mental illness.

I will make a few opening remarks about the structure of this motion. To put it in context, on Monday night on Channel 7 a program exposed a series of tragic cases of suicide at Graylands Hospital. Within that was a call for an inquiry. I will address that issue, and I hope that today we will get a response from the Government about whether it intends to listen to that call for an inquiry or, alternatively, to merely dismiss it. The cases of suicide must be seen in context; they do not just happen. The context in which members on this side of the House see those tragic cases is one of under-funding in mental health, particularly in community-based services to support those who are affected and afflicted by mental illness once they are discharged from an institution or in fact are never admitted to an institution. That is the majority of people in our community who suffer from a mental illness.

The third part of the motion may well be dismissed out of hand as being mischievousness on the part of the Opposition, but it is a serious comment. All of us must take seriously the needs of mentally ill patients. Mental illness and psychiatric services typically are never taken as seriously as other parts of the health services. I take them seriously. If we only opened our eyes, everyone in this Chamber would know of somebody who is suffering from a mental illness. What is worse than that is that all of us have probably come across tragic cases of youth suicide. That is the context in which I have formulated the motion and I will now address it in greater detail.

I saw the program on Monday night, and no doubt a number of other members also saw it. I hope that those who did were struck by the absolute tragedy of the families who were the focus of the program - the tragedy of losing talented and beautiful young people. When these young people were not suffering from a mental illness, they had the world at their feet; yet these families have suffered tragic losses. For the benefit of those who did not see the program and are perhaps not familiar with what I am talking about, I will refer to those cases so that we are talking the same language and members understand where the Opposition is coming from.

We learned about Romuald Zak. Six days after Romuald disappeared from his ward, he was found under a tree on the perimeter of the hospital grounds near a pathway. His body was badly bruised, his face was covered in blood, and cigarette burns were on his hands. The Zak family cannot understand why there was not a comprehensive search for their son around the hospital grounds and how his dead body lay unnoticed for so long. Other elements about this case are still without answers. The case is now the subject of a formal request to the Attorney General for a second coronial inquiry.

Gretel Fell-Smith initially sought help from Sir Charles Gairdner Hospital. However, on 19 January last year she admitted herself as a voluntary patient at Graylands, depressed and suicidal. Within 24 hours she was dead. She was found hanging from a curtain rail in the admissions ward. Because she was depressed and suicidal at the time, she was supposed to be watched closely and checked every 30 minutes. The management of the hospital admits that this did not happen.

Thirdly, Melissa Saunders was 22 years of age and was more or less a street kid. She suffered from a personality disorder. She had been treated at Graylands on 10 occasions between 1996 and 1999 and was well known to the hospital. Staff were aware that she needed medication for her epilepsy and other conditions. She was finally admitted on 5 April last year. The coroner found that Melissa had choked to death after having an epileptic fit. She was in a secure ward, and staff were supposed to watch her closely because of her condition. Melissa was very large, and her family cannot comprehend that no-one noticed she was having a fatal seizure.

The final case does not concern a person who falls into the young category. However, the case is important because of the particular circumstances. Noreen Egan had been a regular patient at Graylands. She suffered from schizophrenia and was a drug user. She went missing on 11 August and was found dead under some bushes some 15 days later; yet the location of her corpse was just metres from a busy pathway.

They are certainly not isolated cases. The rate of inpatient suicide to admissions of patients at Graylands has increased steadily over the past 12 years, both in absolute terms and in ratios. In 1987, the ratio of suicides to admissions was one suicide to 660 admissions. In 1999, it was one suicide to 291 admissions. Therefore, the rate of suicide has increased

threefold over that decade. It is not incremental in any way, but the pattern is one of a general increase. Those are worrying figures indeed. Over the past 13 years, there have been 100 deaths at Graylands, 61 of which were suicide. Thirty suicides have occurred in the past four years. Therefore, over the past four to five years, there has certainly been what would be described as an alarming and dramatic increase in the number of suicides. I am talking only about Graylands. I will comment on the other institutions as I proceed.

As a result of the program and as a result of seeing those cases of, on the whole, young, tragic suicides, the Health Consumers' Council WA called for an inquiry into these figures. The parents of the young people are also demanding answers, not only about their own individual cases but also about what appear to be systemic difficulties in the delivery of care in an inpatient situation. We also learned that a former Graylands psychiatrist who had years of experience in the hospital has added his support to the call for the inquiry. Hence, apart from putting on the record the absolute distress of these families, my desire tonight is to ask the Government what is the response to that call for an inquiry. I have spoken with the families of all the people I have mentioned except for one. The families are pleased that Parliament will consider their plight. They are pleased that there will be some serious consideration of an inquiry because that is what they are entitled to at the very least. These families have lost their very talented and special children and their grief is all the more heart-rending because of unanswered questions. I will dissect the cases and tell the House what those unanswered questions are, and there are quite a few. The first and obvious one is how can inpatients go missing for days without their absence being noticed? How could corpses be undetected for six and 15 days? Why in cases where observation was needed were the 30-minute observation checks not undertaken rigorously? Why were known suicidal, vulnerable patients not adequately monitored? Were correct doses of medication administered? Were there breaches of protocol in the failure to ensure that doors which were supposed to be secured were properly secured in areas where vulnerable patients who were prone to self-harm could take their own lives? Were staffing levels adequate for the hospital's duty of care obligations? These are just some of the questions which must be posed as a result of these cases. Each individual case has its own set of questions, but I am not dealing with the individual cases tonight; my concern is whether there are systemic problems which need to be further investigated.

Members might have seen the letter in today's *The West Australian* from the mother of Gretel. She pleads with the Government for a re-evaluation of Graylands Hospital for the "Gretels of the world who are reaching out for the help that is deprived them in today's society." At the least tonight I expect the Government to respond to the question of whether it is prepared to hold an inquiry to evaluate whether the proper processes of care and attention can be guaranteed. Following the publication of the letter today, Jann McPherson, the mother, has received many telephone calls from parents who have experienced similar concerns in similar circumstances. The message to her has been that she is on the right track - others have experienced similar problems with their children and they are concerned; some of these children have suicided.

The Mental Health Association has also received many calls as a result of the Channel 7 program. That program touched many nerves and created in the community a response about the level of care at Graylands. However, the interesting reaction, particularly to the comments from the Mental Health Association, prompts me to call upon the Government to broaden any review of services. I say that because the people who are registering concerns are saying that they need an independent review and that there are sufficient concerns to require a degree of separation between the Health Department which delivers the services and whoever conducts the review. However, over the past 24 hours we have learnt that the problem is not confined to Graylands. We know that Graylands is the psychiatric hospital, but Royal Perth, Sir Charles Gairdner, Fremantle and Joondalup hospitals all have units to deal with patients who require attention for their mental illnesses. People are calling for a review of all those institutions and for any inquiry not merely to focus on Graylands. It is not merely a problem, however grave it is, of inpatients suiciding; there is a degree of wisdom among those who are closely involved in the mental health area that there is a connection between suicidal behaviour and discharge from a psychiatric unit and a relationship between suicide or attempted suicide and refused admission. I know that might be a difficult area to investigate but if the Government is serious about coming to terms with what is happening, it will need to, first, have an inquiry and, second, broaden it to ensure that we do not merely focus on Graylands as that can be problematic. We need to reassure the community, Government and the Parliament that procedures are in place in all psychiatric units and that we have looked at the effects of premature discharge and refused admission on suicidal behaviour. The message I am getting from those who work intimately with people with mental illness is these are the pressure points and the areas which we need to examine.

However, at this stage I want to make the point that any inquiry must not have the effect of causing a knee-jerk reaction in the Graylands Hospital, in any other psychiatric unit or in the Health Department. There is a fear that there will be a reaction because of the exposure which had to happen and that the reaction will be more punitive. People are saying that there needs to be an inquiry but the work needs to build on the positive directions which have been taken and on the therapeutic programs which are operating; programs of which there are not enough. I repeat, there is a fear that patients who are already in Graylands will find that things will tighten up in a way which will harm their chances of normalisation and of resuming a healthier, more balanced level. It would be absolutely tragic if that was the case and I am guarding against that happening.

We need to recognise that some programs which have been introduced into the system are positive, such as work on a primary care approach in which there is an opportunity for the nursing staff to build relationships with the patients. One of the characteristics of the feedback is that the environment in the hospitals is not conducive to building positive relationships between the patient who needs that care and attention and the nursing staff. We need to investigate why that is not happening as a general characteristic. Is it under staffing? Is it an ethos? Is it to do with the shifts? I do not know but if that is a characteristic of our hospitals, then it needs to be investigated. However, the response to the comments about

bodies not being found should not be to cut down the bushes in the hospital grounds. That is apparently something which has been mooted or has happened in the past 48 hours. That may not be correct; the minister may be able to say that that is not happening. However, if it is, it is symptomatic of what is going wrong. It is not a question of cutting down the bushes so the environment is even worse for the patients; it is about having appropriate security, lighting and so on. Already there is a genuine fear that these things will happen as a knee-jerk reaction. That is why the Government should indicate its response to the call for an inquiry.

One concern - perhaps it is not a matter for the Minister for Health, but this is a good opportunity to raise it - relates to the delay in the coroner producing his report on a number of the cases. That has caused enormous grief for these families. In these instances, that should not happen. The reasons for the delays in the coroner giving his response should be investigated, but not as part of the inquiry for which I am calling, rather in another context.

As I said earlier, the Zak family has asked the Attorney General to hold another coronial inquiry on the basis that a number of characteristics of the case were not examined. Members of that family have suffered enormously. They were not even called to identify the body. A staff member from the hospital formally witnessed the body. The mother of this young man never saw him from the time of his death, and that is a very tragic element of this case. I hope the Attorney General will give consideration to other questions relating to this case, particularly, that there are significant discrepancies between the evidence of the coroner and that collected. I do not wish to get into that individual case. I am calling on the Government to respond to what appears to be systemic problems in the mental health area.

The figures on suicide are quite appalling. I think it has been said that in a psychiatric unit, where the type of patient is more prone to self-harm and to mental disorders, we would perhaps expect the rate to be higher. That is a cop-out answer and one that cannot be used here to justify why 61 patients have committed suicide in an environment or institution that is supposed to be protecting and dealing with people with that illness. It does not make sense, cannot be justified and is an appalling circumstance.

The second part of the motion goes to the level of resources and funding. Again, the minister will probably respond by saying that the money has never been as good as it is now; that the Government has injected $40m into mental health over the past four years; and that everything is sweet. Well, everything is not sweet. Although the figures may indicate that money has gone into institutional care, people are also moving out of that care at a rate which is disproportionate to the services on the ground in the community to support the early discharges.

Mr Barron-Sullivan: Is the member saying that the increase in funding has not had any effect?

Ms McHALE: Did I say that? I will leave it to the member to work out what I am saying. For clarification, I am saying that there are insufficient services on the ground in the community to support people who have a severe mental illness.

Mr Prince: Does the member accept there is a lack of suitably trained people?

Ms McHALE: I am saying that there is a trail of evidence to indicate that when people need emergency care and treatment of that nature, sufficient resources are not available; therefore, people who are treated better in the community end up in institutional care. They are not acute patients, but because of a lack of care they end up in inappropriate care which costs more, has its own set of problems in reacting to such -

Mr Prince: That was well documented by the task force in 1995.

Ms McHALE: If the minister knows what was well documented, it is a pity we still see these increases in the number of suicides.

Mr Prince: It takes a fair bit of time to train psychiatrists and mental health nurses. They are a special breed. It is difficult.

Ms McHALE: Is the minister saying that everything is sweet now that these things have been set in place?

Mr Prince: No; I did not say that. I just said that I know from my experience that it is difficult.

Ms McHALE: I know the minister is trying to defend the Government. The reality is that people are suffering, particularly those in rural Western Australia and Aboriginal communities, and the minister knows that very well.

Mr Prince: Yes, I do. I had charge of that for some time - I think before the member came here. There is a dearth of psychiatrists worldwide.

Ms McHALE: The problem is that the minister is focussing on psychiatrists.

Mr Prince: No. I meant the mental health nurses.

Ms McHALE: A whole raft of services could be provided that do not require psychiatrists - that one-to-one care - but the community development model is not there and it must be.

Mr Prince: It is there, but it is slow to get the requisite trained people.

Ms McHALE: There is ample opportunity for that. I come back to some of the problems at the Graylands facility. Let us look at the annual report of the Council of Official Visitors, which lists a number of concerns. The minister has also confirmed that in some instances these people require secure beds, but they are not available for them. I will tell members about some of the problems as a result of insufficient bed numbers. They include placing additional beds in already

crowded or less than ideal rooms, resulting in restrictions to privacy and a lack of facilities for storing belongings. The hospital has had to convert lounge rooms, seclusion rooms and other rooms to bedrooms in secure cases. Patients are required to remain in closed wards when ready for a transfer to open wards, due to the lack of beds.

The Government closed beds at the Graylands Hospital on the basis that beds were to be available at the Joondalup facility. In general terms, the figures for the patients from the Joondalup area, who were in the Graylands Hospital, declined when the Joondalup facility first opened, but now they are rising again. Having closed beds on the pretext that the Joondalup facility will take the people, those Joondalup patients now appear to be coming back to the Graylands Hospital, and that must be investigated.

I will just clarify where the difficulties are. A Government that is serious about dealing with mental health must look at these issues. There are difficulties for Aboriginal groups, those living in rural remote areas, and those who experience mental health emergency in accessing services. Yet, the psychiatric emergency teams - PET - are restricted. It is possibly too soon to tell whether that has had a bad effect but the general view is that the decentralisation of the psychiatric emergency teams has reduced the services that are available in an emergency and people who have experienced sexual abuse find accessing services difficult, and so on. Therefore, member for Mitchell, I am not standing on my feet to say that no money has been put into the system. I am saying that money is not being properly directed and I question where all the money has gone if $40m has in fact gone into the system.

Mr Prince: Yes, it has.

Ms McHALE: A range of services that is not being provided is urgently needed, accommodation being one. Carer support for family members who are actually coping with a person who has a severe mental illness is urgently required. One of the difficulties for a person with a mental illness is finding employment. There is, therefore, a need for programs which facilitate re-entry into the workplace. These are the types of programs that are needed together with consumer advocacy, consumer participation and general advocacy services. Governments sometimes shy away from providing these kinds of services because they are confronting and lead to a greater focus on what is needed. It is well known, for instance, that there is a dearth of information for patients on their rights when they enter Graylands. A brochure may well be provided to them but a patient admitted in a disorientated state needs more than a brochure. That is a minor example; however, it typifies many of the problems that exist.

Because I am keen for the Government to respond, I may stop at this stage and exercise my right of reply. I bring back the discussion to the following point: The cases that we heard about were not one-off cases but, rather, part of a pattern in society that has been increasing over the years. That is not acceptable in a caring society. The families of those involved are now demanding an inquiry. I want to know whether the Government is willing to undertake an inquiry and whether it is prepared to extend the inquiry to investigate other in-patient institutions or whether it will continue to dismiss the call for an inquiry.

Finally, it would be helpful to those who fear a more punitive response to be assured that the developments that have occurred will continue and that patients will not be subjected to a more punitive, restrictive regime.

MRS HODSON-THOMAS (Carine - Parliamentary Secretary) [6.43 pm]: On behalf of the minister and members on this side of the House, I extend my sympathy and compassion to the families who have lost their loved ones in such tragic circumstances. I also extend sympathy on behalf of all of the people working in the mental health system and the services. They, too, have shared the same feelings as we do for all the families affected by these tragedies. It is natural for all families to ask why their son or daughter has suicided and to question the system of care that appears to have failed them. Unfortunately, it is not always possible to answer the question of why a young person would choose to take his or her life. It is possible to look at the circumstances surrounding the death but it is almost impossible to understand what caused a person to take his or her life. This always makes it very hard for those grieving, especially parents, who naturally expect that a child will outlive them and that a young person with his life ahead of him has everything to live for. I also have experience of a member of my family who committed suicide. I therefore feel for people who find themselves in these circumstances.

The Government has in place measures to constantly review the system; for example, coronial inquests, management reviews conducted at Graylands, regular external scrutiny of care at Graylands and other authorised facilities. The coroner fully investigates suspected suicides through coronial inquests, including the contribution that the system of care may have made. In two deaths at Graylands for which inquiries have concluded, the coroner reported no deficiency in the care, treatment or supervision provided by Graylands. It appears from her comments that the member for Thornlie lacks faith in the coroner or the coronial system. After every death in Graylands a management review is conducted in order to assess the risk of future deaths. Changes have been made; for instance, since 1997 patrols of the grounds and perimeter have been improved and bushes have been cut down - certainly not in the past 48 hours - to make it easier to see what is happening. A balance was kept between pleasant gardens and easier visual security, physical alterations to minimise the opportunity for suicide were made and in-service training for staff on suicide risk has also been implemented.

Ms McHale: When were they done?

Mrs HODSON-THOMAS: Certainly since 1997, as I just said.

Ms McHale: Since then there have been 25 suicides.

Mrs HODSON-THOMAS: I will continue my remarks. In-service training for staff on suicide risk and increased one-to-

one special nursing for high risk patients have been instituted. The additional recurrent costs of these measures is approximately $140 000 a year, of which $90 000 has gone into one-to-one special nursing. Graylands also has a very close relationship with the police. If a person is missing, Graylands immediately notifies relatives and the police and searching begins. Regular external contact with patients in Graylands and other authorised facilities occurs in addition to Graylands administrative and clinical decisions being open to review. The Council of Official Visitors regularly visits and reports to the minister on conditions at Graylands. I recently attended Fremantle Hospital with the Council of Official Visitors so I know the kind of work performed by the council. Patients are able to talk about any topic with the Council of Official Visitors and the council will pursue any matter on their behalf. Involuntary patients may appeal their status to the Mental Health Review Board and the board routinely reviews the need for involuntary status. In addition, the Office of Health Review is available should any patient or family member be dissatisfied with the resolution of a grievance by management. The Ombudsman may also conduct an investigation of any administrative decision and the Office of the Chief Psychiatrist is responsible for the standards of clinical care and can investigate any matter related to the treatment of patients. The Mental Health Law Centre is also available to assist patients. It is important to acknowledge that certain patients are at elevated risk of suicide. Those admitted to Graylands or other psychiatric hospitals are experiencing an acute episode of illness and are extremely vulnerable, which is an important point.

I refer to some research conducted by D'Arcy Holman, a University of Western Australia professor of public health, who found that most suicides by people treated for mental illness occur within the first four to six weeks after discharge. The member for Thornlie touched on that point. The recovery phase from an acute episode is difficult for the person and the clinician. The clinician must make a judgment about the degree of freedom a person is ready for in circumstances over which the clinician does not have complete control. A person recovering from an acute episode can be set back by unpredictable and sometimes seemingly minor events, such as an argument with a family member or a friend. Professor Holman's research looked at suicide by psychiatric patients between 1980 and 1995, during which time the total number of patients who suicided was 943. The number of people treated by mental health services in that 15-year period was 52 190, of whom 1.8 per cent suicided. Although it is a low proportion of the total number of patients treated, it indicates how difficult it is to identify precisely who is at risk. Most suicides occur when a person is not under direct care. Of the 24 deaths at Graylands over the past three years, 10 occurred at hospital and the rest occurred when people were on leave or away from the premises.

The Metropolitan Mental Health Service introduced a policy during 1999 that all persons discharged from in-patient treatment were to have contact within five days by the community mental health service which assumed responsibility for their care. The clear intent of this policy is to reduce the number of suicides which occur after discharge. The existing systems, especially the coronial system, are in place to investigate unusual deaths, although I wonder whether an inquiry would relieve the grief of a family or answer the unanswerable.

In my role as Chair of the Ministerial Advisory Council on Mental Health, I take all the matters raised by the member seriously. In terms of funding for mental services, I remind members that a Ministerial Task Force on Mental Health was established in 1996 by the member for Riverton when he was Minister for Health. It was established to make recommendations to improve services for people suffering mental illness. At the same time, the Health Department produced a report entitled "Making a Commitment: The Mental Health Plan for Western Australia". The priorities for reform were the need to allocate substantially greater resources to mental health; an identifiable mental health service structure within the Western Australian health system; modern health legislation giving appropriate protection to the rights of patients; as well as the development of a comprehensive range of community based mental health services. The reform is not over, it is ongoing.

This development highlights the Government's ongoing commitment to mental health. In terms of specific reforms, the State Government, as the member opposite acknowledged, committed an additional $40m over a three-year period for the mental health reform process. This is equivalent to $20m of recurrent funding overall, and a further $47m was committed over five years to building programs to support the reforms. Throughout the three years of the additional funding, the mental health program has been quarantined so the money is not taken up by any other components of the health system.

Another part of the reform was the formation of the mental health division, which has responsibility for statewide policy development, broad strategic statewide planning, investing in or purchasing services and managing a variety of statutory responsibilities. The general manager of the division is also the Chief Psychiatrist of the State.

Next Step, the former Alcohol and Drug Authority, was split into this Western Australian drug and alcohol office and health related services. Policy and planning for these health-related services was transferred to the mental health division. It is important that Next Step be linked closely with mental health as dual diagnosis is a major issue for many people who suffer mental health disorders as many also suffer from alcohol and drug problems.

The Mental Health Act 1996 imposes a number of safeguards for people with a mental illness to ensure that their rights are fully protected. At the same time, these people can receive the care and treatment they require in the least prescriptive setting. Involuntary patients are able to be treated not only in an authorised hospital, but also in the community under a community treatment order, thus minimising unnecessary hospitalisation. The Act also established the Mental Health Review Board and the Council of Official Visitors. Patients are entitled to written and verbal information about their legal status, and to obtain copies of orders made about them. Patients can ask the board to review their case and care. They can have a visit from the Council of Official Visitors, and can make complaints to hospital authorities, the Council of Official Visitors or even the Chief Psychiatrist. Patients can obtain a second opinion from another psychiatrist. Patients can have a person of choice with them when discussing their treatment with their psychiatrist, and can obtain legal advice. Patients

are provided with a list of phone numbers and addresses of people whom the patients can contact regarding any of the matters outlined above.

Mental health services have been structured on a regional basis to enable strategic mental health service planning and purchasing. After the first two years of the reforms, a 23 per cent increase occurred in staffing.

Ms McHale: You will probably not leave me time to reply. Will the Government have an inquiry or not?

Mrs HODSON-THOMAS: Can I just finish my remarks?

Providing services in the community will increase accessibility and reduce the stigma and encourage the inclusion of people with mental health difficulties into the mainstream community. This process is part of the philosophy to place people in hospital only when very unwell and in need of a short, intensive period to stabilise their illness.

Community support services provided through the non-government sector also have been significantly expanded. Western Australia allocates a larger proportion of its mental health budget to this sector than that provided in any other State in Australia. The main focus has been the extension of supported accommodation, about which the member opposite spoke.

I now refer to options for people with serious psychiatric disabilities. As well as crisis and respite care, programs have been established to prevent unnecessary hospitalisation by supporting people while they are able to maintain their housing, and by allowing discharge from hospital for people who still need to find housing. This Government has provided many positive initiatives in the area of mental health, and it is working towards a funding mix of 50 per cent to community services and 50 per cent to in-patient services. Significant progress to date has been made towards achieving this mix. The community services in Western Australia in 1998 and 1999 received 39.6 per cent of the total state mental health services funding, which compares with 26.3 per cent in 1992 and 1993.

[Leave granted for speech to be continued at a later stage.]

Debate thus adjourned.

House adjourned at 7.00 pm