

Hello,

I was listening to a professor graham Martin and his involvement with the senate enquiry, and would like to make the following submission.

We lost our 33 year old daughter Jennifer to suicide in 2007. We believe that this was preventable. She struggled with suicidality for over 10 years. She self harmed.

She was highly intelligent, articulate and gentle person.

During her struggle she willingly participated in any programs that she thought might help her. She said she did not want to die, she just wanted to feel safe, and be free from mental anguish.

Because of our prolonged involvement with her treatment we were able to see and learn a great deal about the kinds of treatments and methods that worked well, not just for her but for many of the other people that we encountered on this horrific journey.

The public mental health system is horrifying and potentially quite dangerous. On more than one occasion she was released from hospital without anyone in her family being informed despite promises that we would be kept fully informed, they were provided with 24 hr contact information, but after the initial involvement....ZIP!

Jennifer quickly opted for private health insurance, however if you are scheduled you are at the mercy of the public system.

Part of her treatment resulted in her entering a private hospital that had various degrees of severity assigned to each patient. Each patient had to sign a safety agreement for the term of their stay. Example code Red meant pyjamas, remaining only in the back courtyard of the hospital etc. The next code involved being able to leave the hospital for short periods with a carer.

It was a complex system but it worked extremely well for all the patients.

At the end of the stay some or all of the following could be involved:

Signing a contract to the effect that in the event of an overwhelming event that a certain procedure would be followed, e.g. calling a list of people, carrying out certain behaviours, agreeing to a 24 hour moratorium.

Release from hospital also involved calling a family conference and the patient only being released finally after having a carer briefed on the medications prescribed and agreeing to the medications being administered by the carer and having that carer pick up the patient.

The first assessment after say 1 week would review the situation and involve the carer in this decision making, until self determined decision making could be restored to the patient. I believe that suicidal desperation reaches a crescendo and subsides for a time. It ebbs and flows and that it can be managed.

What I believe should happen is that if the patient has a support system a survival kit should be given to their support system, and it should be reviewed at least biannually or annually by the support team if it is considered that the patient could still be at risk. That risk should be assessed by not only the mental health team but in conference with the patients support team, a patient might well tell the mental health team what they want to hear but the patients family may know much more than is being placed on the table.

We were never given any written information on what the overall risks were long term.

We were not given a written list of the medications and what risk they could pose.

We were not warned that the medications could be hoarded.

My daughter's last admission to hospital was not to the hospital that she had stayed in on many prior occasions. It was shabbily run, including a gross lack of dietary care. Jen had not needed to be hospitalised for over 2 years, she was doing really well.

Jen was treated with contempt by a certain hospital staff member and she asked for intervention. This did not happen, she was extremely distressed by this.

Jen severely self harmed during her hospital stay.

We were not informed that she self harmed.

Jen was not scheduled after this incident which is supposed to be mandatory. If she had been scheduled we would have automatically gone into "high" alert. We were not told and so did not have the information that we needed to enact our well designed safety precautions and care.

Jen had revealed to hospital staff that she was severely suicidal.

They did not inform us that she was suicidal.

They released her anyway.

During her stay Jen and two other patients were removed from the mental care ward and housed on the surgical ward for a night when they reacted with fear to the fact that a man would be on duty and they had made repeated requests that this not be the case. These three women had been sexually traumatised when they were children.

Jen was released for the Easter holidays because there was very little staffing.

Jen was not asked to sign a safety agreement, which she had honoured 100% successfully on ever occasion that she signed one.

We were not given the opportunity of a family briefing, despite requesting one a number of times during her stay, something that she always agreed to if asked, and had agreed to in discussions with me on this occasion.

We were not informed of her medications.

Jen was given prescription renewals.

Jen had them all filled. I have a photo of the bag of prescription drugs she was given on discharge It is the size of a reusable supermarket 99 cent bag.

Jen died 5 days later.

10 years with the other hospital and all the methods that worked, one stay at this hospital and she died. She died because they can hide behind privacy laws. She died because of lack of liaison and information being provided to mental patients and their families. She died because the things that work are not documented and adopted. She died because not enough information is provided to their families or friends network, despite the fact that it is these people that carry the majority of the responsibility of care. She died because there is no survival kit for the patient and their carers. There is not an ongoing carer management plan, nor any information on how a family can maintain one. No explanation of the exhaustion that they may feel, the overwhelming fear, the helplessness with the system and its workings. No apparent place to go to voice these problems.

Sometimes you are informed and sometimes you are not, sometimes your loved one is treated with contempt and sometimes they are treated with great compassion, its all "luck" not policy. It is wrong!

There should be patient/carers/hospital/doctors communications strategy. You hear that these strategies exist, and they do to some extent, but they are not guaranteed.

There is also very little opportunity for carers to get their feelings, and fears and questions out into the open, they need to be part of the treatment plan. You mostly feel invisible.

Thank you, I am prepared to elaborate on my statements, and collaborate in any way or be of assistance in any way.

Most sincerely,

Carolyn McKensy.