Submission to Senate Standing Committee

on

Community Affairs

Inquiry into Suicide in Australia

By

Graeme Bond

Introduction

The terms of reference for this inquiry makes specific reference to high risk groups such as indigenous youth and rural communities. I have no specialist knowledge of these groups but can only comment on personal experience in urban Australia, firsthand accounts from others in a similar situation and general study and observation over the past 16 years since the death of my eldest son.

Background

I am the father of a young man who committed suicide in 1993 after an 11 day experience with the mental health system, 8 days being in a hospital that discharged him 3 times in most alarming circumstances. He died 28 hours after his third discharge. I have written elsewhere of this experience and attach an article I wrote for The Age newspaper and which was published in March 2004[1].

Response to Specific Terms of Reference

a) the personal, social and financial costs of suicide in Australia

Circumstances surrounding each suicide vary and so too will the consequences and the personal, social and financial costs.

In some cases I am aware of, the suicide has occurred after a long period of mental illness and previous suicide attempts. In other cases the first relatives and friends knew of problems was when there had been a completed suicide. My son's case lies in the spectrum in between but toward the shorter duration.

Where a family endures a long period of dealing with a person with a mental illness and the dread of an eventual fatal outcome it is a debilitating experience and there is insufficient support available for such families as they struggle to avoid their worst fears. The costs would include disruption to family life, physical assaults sometimes endured, damage to property, disruption to employment or business etc. I did experience some of these to a small degree.

Following a suicide the effects are profound and include some or all of the following:

- Guilt – even where rational thought says there should be none
- Depression or at least a deep sense of grief and isolation
- Assaults launched on the family by lawyers acting for parties such as Hospitals, Doctors and the Department of Human Services when a suicide victim has had contact with the Mental Health System and an inquest is to be held
- Financial institutions manoeuvring to secure a charge over assets due to higher perceived risk
- Business failures or at least massive stress
- Unemployment

- Insurance companies refusing claims on disability income policies when ones mental state and deep distress and grief prevent effective work or causes unemployment
- Financial loss – in some cases running to hundreds of thousands of dollars
- Family breakdown or at least [as in my family's case] extreme pressures tending to tear a family apart
- Disturbed behaviour by siblings lasting many years and having educational and other consequences
- Individual family members irrationally shouldering guilt and blame to the point of developing a mental illness and themselves becoming suicidal
- Vulnerability to exploitation
- Susceptibility to exploitation and bullying behaviour as others appear to sense vulnerability in environments such as the workplace

These effects can be mitigated by actions such as:

- Proper postvention by mental health authorities [even where there has been prior contact due to the deceased being a patient this may not be provided]
- A supportive work environment, something that is comparatively rare but of immense value
- Peer support groups such as The Compassionate Friends [2]
- General Practitioners providing support and appropriate referrals

Additional support that should be available, but to my knowledge, generally is not:

- Legal assistance to deal with matters such as inquests and any issues resulting from the death
- Where appropriate, expedited support by government agencies such as Centrelink to reduced financial stress
- Postvention where not already provided [most cases]

b) the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk)

Accuracy of reporting

I have uncertainty about the accuracy of statistics produced by Coroner's in relation to suicide for a number of reasons.

There have been cases where a Coroner has appear to bend to the desires of a family to have any finding other than suicide due to social stigma, religious or other reasons. This may assist the family deal with their individual concerns but it distorts the overall picture. At least some such cases have been reported in the media. How many go unreported?

There are also a significant number of single vehicle accidents, drug overdoses and other accidental deaths which could be suicide but it is really not possible to say definitively. These perhaps should be kept in a separate category as possible suicides and monitored.

It also appears that the DHS / Department of Health statistics are out of date by the time they are compiled and made available. This diminishes their value as a management tool.

I think it would be desirable for responsible Department of Health management, researchers and others to have monthly statistics available to enable timely observation of trends in response to any departmental initiatives or other factors. It is an old truism that 'what you don't measure you can't manage'. Monthly statistics may be subject to later revision but statistics that are 12 months or more out of date are of historical interest only and do not assist policy monitoring or timely response to any emerging trend.

I do not know the situation in other states but, in my opinion, the best information on the Mental Health System in Victoria has come from the Victorian Auditor General [3]. I would very much like to see the Auditor General's office look into the collection and use of suicide and other death statistics in Victoria from the perspective of their use as management and clinical effectiveness tools, rather than historical records, and make recommendations to the State Coroner and the relevant government departments.

Factors that may impede accurate identification and recording of possible suicides

One factor I believe impedes the accurate identification and recording of possible suicides is the quality of the investigation conducted by police and the length of time taken. I take 'recording' to include not the mere fact of a suicide but also relevant surrounding circumstances.

In my sons case and, I believe in most other cases, the investigation is carried out by the police member who attends the scene. This is normally a uniformed member with no specialist investigatory training or skills.

This may be sufficient in simple cases, but I venture to suggest that not all such cases are simple, especially if the investigation is to delve into medico-legal issues as they should when a person is in care, recently discharged, or refused care.

Skilled police investigatory resources may be in short supply but I believe cases should at least be screened by a specialist investigator within 24 hours to determine if other than a routine investigation is warranted.

In my sons case, the investigation appeared to rank in importance somewhere around the level of parking infringements and languished for many months with an ordinary uniformed constable. After months of agitation on my part, letters were eventually sent to police stations closest to the residence of witnesses to request that a statement be obtained. So simply gathering witness statements took many months!

Throughout this time no effort was made to obtain medical records or obtain statements from hospital staff. Indeed, the full medical history was only produced by the hospital during the coronial hearing. When I later obtained a copy under FOI it showed possible evidence of at least one significant alteration. I believe the practice is for the Coroner's office to now secure such records as soon as possible to exclude, as far as possible, the opportunity for any tampering .

The obtaining of witness statements from medical staff was 'outsourced' to the hospitals solicitors! Not only did the solicitors control what went into the statements, they also selected who would give a statement so that any 'inconvenient' witnesses could be excluded. This is hardly an objective investigatory process.

I have commented in greater detail on these and other shortcomings in my submission to the Victorian Parliamentary Law Reform Committee Inquiry into the Review of the Coroners Act 1986.[4] I believe the new Coroners Act addresses at least some of the concerns I, and others expressed, at the inquiry.

Understanding risk factors and providing services to those at risk

There is a considerable body of literature on clinical risk factors and warning signs and it seems to broadly agree.

What does seem to be most lacking is a 'risk management' approach and it seems that clinicians and staff are frequently prepared to expose a patient to a high level of risk.

The Australian standard for Risk Management, AS/NZS 4360 provides a generic methodology for assessing and managing risk. A key element is that it examines a risk in two dimensions, likelihood and consequences, and then applies a method of combining both factors to arrive at a risks rating. Even if a risk has a relatively low likelihood, but the consequences are severe such as death or serious injury, the risk achieves a high ranking and the standard mandates credible action to mitigate the risk. So if the consequence could be death or serious injury, even a low likelihood will still achieve a high rating requiring effective mitigation action.

It appears from my observation of the mental health system in Victoria [supposedly one of the better states] that there is no such rigour in ranking risks and taking effective action to mitigate risk

of death or serious injury through a suicide attempt. Patients who require a safe in-patient environment and close observation are routinely discharged – in my son's case 3 times in an 8 day period! Other persons who are brought to Accident and Emergency at a public hospital by concerned relatives or police are all too often turned away with no significant assessment.

One doctor in charge of a major public hospital documented 13 cases in a 13 month period where such patients committed suicide or, in another case, returned home and murdered a partner. [5]

Quite clearly, unacceptable risks are being taken with patients lives and it is happening on a significant scale.

Many mental health patients are treated in the community and this is predicated on the availability of Community Assessment and Treatment Teams [or their equivalent in other states]. It is an unfortunate reality, except in the parallel universe inhabited by State Health Ministers and senior departmental officials, that there are just insufficient CAT Teams. Consumers routinely refer to them as 'Can't Attend Today' or 'Call Again Tomorrow' Teams. Aside from the issue of their scarcity, the teams, or those directing them, appear not to always exercise good judgement, sometimes preferring to attend to safe routine cases rather than a real crisis.

This creates a situation where most mental health crises, including those with suicidal patients are attended by armed police, all too often with deadly consequences. As the Victorian Auditor General documented in a report released in November 2009, CAT Teams leave the police to attend the crisis, preferring to assess the patient later in police cells. Police cells are not a therapeutic environment and police are not sufficiently trained to deal with disturbed patients.

c) the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide

Police

The involvement of police in dealing with suicidal people is much greater than is reported in the media as it is only the cases where something goes wrong that are reported. The vastly greater numbers of cases where police are called to assist and do so, with varying degrees of success, naturally go unreported.

So let me place on record my appreciation of the efforts of police generally so that this can appropriately balance any negative comments I may make.

Police are given very limited training in dealing with mentally ill and / or suicidal people. It is difficult to see how the training given can ever be sufficient for them to effectively take the place of properly trained front-line mental health workers [as seems to be expected of them] when there are so many other demands to be met in their training.

Recently the Victorian Auditor General has released a report critical of psychiatric patients being conveyed in the back of police divisional vans and being assessed in police cells. I agree wholeheartedly, but what alternatives do police have?

The answer is usually none!

Even in cases where police are endeavouring to deal with a severely disturbed psychiatric patient, CAT Teams will not attend and ask police to take the patient to police cells for assessment. As was seen in a case in my suburb in 2002, this ended up with police using deadly force. With skilled professional advice on hand the outcome should have been different.

This poses a dilemma for family trying to deal with a disturbed person. A call to the Mental Health Triage will result in the advice to either take the person to Emergency Department [if they will go] or call an ambulance [which will only take them if they are docile, compliant and agree] or call the police [who will arrive armed, in uniform and, to the patient, threatening]. Some choice!

The former State Coroner, Mr Graeme Johnston, in August 2005 called for Police to be issued with Tasers.

The problem with any such equipment is that it tends to be used and the threshold for the use of such a weapon is lowered as it is 'non-lethal'. In my experience the best equipment police have had has been their common sense and a degree of patience. I have been surprised how well some young constables have performed. They used their wits and ordinary humanity with great patience and achieved a successful outcome.

Emergency Departments

Emergency Departments of Hospitals in Victoria have been burdened with psychiatric patients since the flawed policy of 'mainstreaming' came into existence.

The effect of this has been commented on by others better equipped than me and I would draw the attention of the committee to an attachment to my submission to the Mental Health Inquiry in 2005 which was a letter written by a Doctor [Dr Peter Archer] in charge of an Emergency Department of a major Melbourne public hospital.

Patients with mental health problems, including some with psychosis and violent or suicidal behaviour, were being placed among patients with physical illnesses and injuries and waiting until eventually a CAT Team would attend and assess them, often the following day. The psychiatric patients may be at the very least disruptive and potentially a source of further injury to other patients.

There does seem to have been some improvement in this situation with greater availability of Psychiatric Nurses to assess patients within a more reasonable time frame.

But all too often patients brought in by police or otherwise, are released with little more than a cursory examination and a trite promise extracted from them not to self harm. Little weight seems to be placed on the factors which caused their presentation to the department and the concerns of relatives, police or anyone else and the behaviours they may have witnessed. All of these factors need to be given proper weight and a more cautious risk management approach adopted.

Law Enforcement

Counsel assisting the Coroner at a high profile inquest in NSW, Mr Ron Hoenig was reported as stating:

"The definition of murder includes an omission or act with reckless indifference to human life as well as an act or omission with intent to cause grievous bodily harm."

I was struck by this comment as it seemed to be all too frequently descriptive of a Mental Health System which fails to apply proper risk management principles and releases or fails to admit patients who present a high risk of suicide.

In the case of my son, this did not occur just once, but 3 times within a period of just 8 days.

The law seems to turn a deliberately blind eye to such occurrences. There is simply no accountability for reckless acts by persons within the Mental Health System and there is a culture of seeming indifference to the fate of patients. Part, but not all, of the reason is that the system is simply underfunded and has inadequate capacity to admit or retain patients that present a significant risk of suicide. The criteria for such admissions seems almost to be 'prove suicide is a certainty', an impossibly high barrier in too many cases.

There are individual cases where staff members do display negligence, but the greater fault lies with the department and there appears to be no legal accountability and no effort to introduce proper risk management and to provide the patient capacity required.

General Health Services

It is often stated that mentally ill patients, some of them suicidal, will present to a GP complaining of other symptoms. It follows that GPs should be aware of this and prepared to ask questions if suspicions are aroused.

I have no specialist knowledge or experience in this area other than to observe that no GP who my son visited had any such concerns aroused as far as I am aware. But then if they did, they would not have been communicated to family because of concerns for patient confidentiality. Patient confidentiality and privacy should never trump safety.

Efforts to improve GP knowledge in this area are to be welcomed and should be supported.

d) the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide

I am unable to comment directly on this as I have not made a study of such programs or been in a position to monitor their effectiveness.

A related issue I will comment on is the abuse of notions of 'patient confidentiality' to deprive next of kin and other carers of the information they need to understand the seriousness of a situation, to care appropriately for a suicidal person and the warning signs to look out for.

I dealt with this matter in my submission to the Senate Select Committee on Mental Health in 2005.[6] I cannot emphasise too much how significant an issue this is. It is a conscious act of negligence to place a family or others caring for a suicidal patient in a position of ignorance about the extent of the risk, what to do in a crisis, warning signs and other vital knowledge.

A patient's safety should trump any misplaced and often inaccurate concerns for 'confidentiality'. The simple fact is, at least in Victoria, the Mental Health Act does allow such vital information to be provided to carers and next of kin.

e) the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk

I have not participated in any such training and cannot make any informed comment on this.

f) the role of targeted programs and services that address the particular circumstances of high-risk groups

I have no specialised knowledge of this.

My only comment of this would be that, as I have discussed elsewhere in this submission, the Mental Health System comprehensively fails many people who are vulnerable by reason of mental illness.

g) the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy

I have no specialised knowledge of this other than derived from the experience of my son's case.

It appears that the Department of Human Services was at the time not achieving notable success in disseminating important protocol documents to practitioners and having them implemented. In particular, a Patient Risk Summary which had been mandated by the Chief Psychiatrist did not appear on my son's Medical History. Similarly, on each occasion he was discharged, the recently issued Discharge Planning Guidelines were not followed. Indeed, at a departmental meeting held weeks after his death and recorded in his medical history, it was clear that no-one in the department, including the department head, was aware of the Discharge Planning Guidelines. The department had its own woefully inadequate procedures.

These are fundamental issues of management.

h) the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress

I have no specialised knowledge of the strategy but believe that any strategy would be handicapped by lack of up to date statistics to monitor progress and quickly identify any changes in trends.

[1] Critical condition, The Age, 17 March 2004, Melbourne http://www.theage.com.au/news/science/critical-condition/2004/03/16/1079199218039.html

[2] The Compassionate Friends http://www.compassionatefriendsvictoria.org.au/

[3] See for example:
Responding to Mental Health Crises in the Community, Victorian Auditor General's Office, 11 Nov 2009
Mental Health Services for People in Crisis, Victorian Auditor General's Office, 17 Oct 2002
Managing Patient Safety in Public Hospitals, Victorian Auditor General's Office, 23 Mar 2005

[4] http://www.parliament.vic.gov.au/lawreform/inquiries/Coroners%20Act/submission.htm Submission 48 http://www.parliament.vic.gov.au/lawreform/inquiries/Coroners%20Act/transcript.htm Evidence including PowerPoint slides

[5] Letter from Dr Peter Archer, Director of Emergency Services, Maroondah Hospital to Minister for Health 15 Feb 2004

[6] Senate Select Committee on Mental Health Submission No 484 http://www.aph.gov.au/Senate/committee/mentalhealth_ctte/submissions/sublist.htm