10 May, 2010

Senate Community Affairs Committee – Inquiry into Suicide in Australia

Thank you for giving us the chance to tell our story because we feel our son's death could have been prevented. We will give a few recommendations that should be standard procedures. Our hope is that in our account of these events we may prevent this happening to others.

On the 6th Feb 2010 our beautiful son Isaac committed suicide. He was 22 years old. It was a terrible tragedy that we will never get over.

From the moment we discovered his body we knew that this was a mistake and that it could have been prevented.

His death has had a rippling effect on the immediate family, the extended family and the whole community.

Our son had a beautiful personality, was sensitive, thoughtful, shy, and brilliant.

Before he left Australia he became depressed. The GP said he had mild depression and did not think he needed anti-depressants at this stage. His mum started him on St John's Wort and Isaac attended counselling with a psychologist who treated him with Cognitive Behaviour Therapy. We thought he would get better once he was with his girlfriend. His girlfriend had travelled to Canada several months earlier.

Isaac went overseas to Canada for a working holiday and to be with his girlfriend. While in Canada he seemed to improve. We were in touch with him most weeks. Sometimes he was hard to contact as he was busy at work, snow-boarding or hiking in some remote part of Canada with friends. He really enjoyed his time there. We thought he was doing well. He broke off with his girlfriend after six months but wanted to stay in Canada because he liked it.

Twelve months after he arrived in Canada he became psychotic and was admitted into the psychiatric ward of St Paul's hospital in Vancouver . We travelled to Vancouver to bring him home. It was a very traumatic time for Isaac and us. He was in hospital for three weeks.

The doctor said he would be released if we had follow-up treatment by a psychiatrist.

We arrived back in Australia and got into a psychiatrist straight away. We were relieved.

For the first visit to the specialist we had to stay outside because of confidentiality. (See recommendation 4.)

The doctor did ask us back into the room for the last 5 minutes of the appointment.

Isaac spent one and a half hours with the psychiatrist. He came out with a form for Centrelink. Written on the form was a diagnosis of Schizophrenia.

I (his mum) was shocked and angry at this, especially after hearing what the other doctor (in Canada) had said. (That he should be given a diagnosis for 12 months and was leaning towards bi-polar)

During visits to the psychiatrist we were not given any documentation for counselling or pamphlets or contact phone numbers.
There were no pamphlets in the doctor's waiting room. The mental health team did not come for a support visit. The whole process seemed to be poorly managed.

Isaac was home with us for 2 months before he committed suicide.

He started trying to socialise and planned a future. He booked in to UNI etc..

In this time the doctor thought he was getting better and reduced his anti-psychotic, ceased his anti anxiety drug.

Two weeks prior to his death the doctor commenced him on Lexapro (anti-depressant)

The doctor gave him a starter pack without any packaging or information about side effects - one of which is suicidal tendencies.
We were not informed that he was "at risk" because of the drug. (see Number 5 recommendation)

As you can see there needs to be changes and the doctors should be accountable for there actions.

Recommendations

We would like to make seven recommendations:-

1. All mental health professionals (psychiatrist etc.) and GPs should have pamphlets or reading materials that are easy to access in the patient's waiting rooms. The pamphlets should cover all the main areas.
    - Schizophrenia
    - bi –polar
    - depression
    - any other mental illness
2. The health professional should counsel patient and carers about their diagnosis. Also they should give contact phone numbers or helplines. i.e. schizophrenia fellowship or Black Dog.

3. Specialist should have notified the mental health team to come and follow up, so there was support for the patient and family.

4. Confidentiality is an issue. When someone has a mental health problem the carers are responsible and the patient usually is too ill to make the right decision. Because our son was 22 years old we were kept at arms length. Carers need counselling and advice.

5. Medication starter packs should not have been given (starter pack is usually one leaf of tablets with no packaging and no information about side effects that has been supplied by the pharmaceutical company.) The medication should always have information about side effects and suicidal tendencies.

6. The doctor should warn the carers and patient regarding the heightened risk of suicide of antidepressants.

7. The doctor should always try to get the patient's medical files if they have been in hospital, even if it is overseas.

I will attempt to address the committee's term of reference individually to the best of my ability:-

a) The personal, social costs and financial costs

The personal side

The devastating grief is so great and so painful. There's something about suicide that makes the loss even greater. It effects your health. We are getting more physical and physiological ailments. It has negatively affected all our family in different ways - and we still just hope

that there are no more follow-on family disasters.

Socially

You become more withdrawn, it effects your work and friends. We do not trust doctors any more.

Financial

It has cost us about $18,000 for airflights and funeral costs. The emotional trauma has cost us greatly. We have been off work for months. We do not know the ongoing effects of this on our health. Most of our family have taken advantage of counselling services - this alone would and continues to cost a considerable amount of money. It may also have had a negative impact on our extended family.

Isaac was a brilliant student and was doing Maths and finance at university. He would have been an asset to our society. Loss of productive income from him. Our other son has not gone back to work yet because of the trauma.

The cost of hospital and medical costs are just a few we can think of.

b) The accuracy of suicide reporting in Australia.

I feel that suicide reporting is under-reported because of the difficult nature of it.

i) How many car accidents are actual suicides?

ii) Drug overdoses?

c) The appropriate role and effectiveness of agencies

When we tried to contact in Wollongong asking for help for Isaac, there was a lack of willingness to help. They seemed to want to fob us off. Perhaps they were under resourced and/or overworked.

While we were in Canada the level of support in their mental health system was good. Isaac was treated well by all the staff at St Paul's hospital. We were advised by the doctors at the hospital that Australia was a good place to get excellent care for Isaac. They specifically mentioned EPPIC and Headspace, so we were disappointed when unable to get help from either of these agencies.

Refer also recommendations 1, 2, 3, 4, & 5.

d) The effectiveness of public awareness programs.

The effectiveness of public awareness programs to date is only mediocre. If as much money was spent on preventing suicide as on road accidents there would surely be better outcomes.

We personally had no awareness of suicide. It happens in someone else's family. Possibly because of shame and embarrassment, people keep their loved ones suicide a secret. This prevents us from seeing how widespread in the general community suicide really is.

Even the well-known groups such as Lifeline and Beyond Blue need some method or actions to appeal to a would-be victim - he/she needs to call for help while in the depths of their despair.

The stigma surrounding conditions such as schizoprenia and bipolar, which often lead to suicide, needs to be removed. These conditions should be discussed in the same way as our other illnesses are treated. Open discussion of problems can lead to better acceptance by all involved.

Terminology can lose people. Our local church had a discussion on "Black Dog". Not everyone would know what this means so it would not attract interest.

e) The efficacy of suicide prevention training and support

As parents we had no training in suicide prevention, yet now we would probably detect the signs. The psychiatrist stated that it (our son's suicide), took him by surprise.
This demonstrates that there is much room for improvement in suicide prevention training.

f) Targeted programs and services that address high-risk groups

Our son fell into a number of risk factors that we should have been aware of.

- He was sensitive.
- He was 22 - right in the middle of the dangerous period.
- He travelled overseas for an extended period of time.
- His relationship with his girlfriend broke down.

We were not aware of any programs that could help our son. It appears that Headspace could have be one program that may have helped him but there was no suggestion or any indication that Headspace even existed.

Conclusion

To us this has been a terrible tragedy and a bad mistake.

There have been failures on so many levels that it is difficult to name one area that was not a failure. As parents we thought we were doing the right thing by bringing our son back to

Australia to live at home with family close by. Clearly, we were not up to the task.

The mental health system was hardly there for our son - he saw a GP once who referred him to a psychiatrist who saw him 3 times.

The drug he was prescribed (Lexapro) may have been the final last straw for our son. It can have and almost certainly did give suicidal thoughts to our son. This is described in the fine print in the packet but to this day I do not know if our son knew or was made aware of this by anyone.

The flow of information from Canadian hospital system to medical people in Australia also seemed to be flawed - as far as we know there was no transfer of any of our son's mental health history back to Australia.

So how many more deaths will it take before people and politicians wake up and realise that suicide is the worst mistake a young person can make - will it have to be your son or daughter before you take action?