"and my son is dead "!!!

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The forgotten ones.

"to speak for the dead and offer hope to the living"
To give meaning to their lives that they didn't die in vain.

Submission
to
The Australian Senate
Inquiry into *Suicide* in Australia

"Learning to lead the way"

"It is a strange trade that of advocacy.
Your intellect, your highest heavenly gift is hung up in the shop window like a loaded pistol for sale."
Thomas Carlyle

Tony Humphrey

President Club SPERANZA

& members.

30th April 2010

AMHSCA
Bringing about "SPERANZA"

Club SPERANZA
Established 1991.
(Australian Mental Health Suicide Consumer - Alliance Inc.)
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Contents & Issues.
Equity, Justice, Accountability.
Minimising suicide by reforming "mental health"

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Suicide Prevention
& Reforming Mental Healthcare in Australia
A Constructive Approach to Total Healthcare.

Professor Patrick McGorry Australian of the Year, 2010
"Mental ill-health is the leading killer of Australians under 45, and the leading cause of disability in Australia."

"I call on the governments of Australia to act urgently and effectively to reform mental healthcare in Australia so that;

- ***there is no longer inequality of access to effective treatments between physical health and mental health***
- ***early intervention is the norm;***
- ***community based treatments are the norm; and***
- ***quality services are the norm"***

Reforming mental healthcare (and minimising suicide) in Australia begins with the need for national attitudinal change.

Inhibiting suicide in Australia means not only reforming mental healthcare systems and services on a national basis, but establishing "mental health" as the driving image in the overall matrix of healthcare reform.

The Elements of National Reform according to SPERANZA:

1. Reduce the stigma with a national campaign marketing a unique image style and public presentation for mental health i.e. assigning to it the colour purple for association in the public mind and immediate recognition of the theme of health in terms of prevention, intervention and recovery.

2. Constructing services to place mental health specialists at or associated as advisers with the head of all health councils.

3. Marketing/promoting mental health as the prime mover in all human enterprise. And a public campaign promoting suicide education awareness and Suicide SafeTALK.

4. Creation of a national mental health commission and state commissioners

5. Creation of an iconic unified mental health service delivery structure and disengaging the association with alcohol and drugs (which is an illness and a treatment stream) not and ideology.

6. A system that recognises and conforms to duty of care and the continuum of care demands, with the avoidance of suicide as its ultimate aim.

7. Emphasis on training and education in suicide ideology for all mental health workers and the community i.e. Applied Suicide Intervention Skills Training (ASIST) and SafeTALK.

8. The establishment of a designated quarantined funding pool for agencies and services specifically engaged in suicide prevention, intervention, and support activities.

9. Recognition and effective implementation of the Open Disclosure Standards for support and financial support for aggrieved families.

Statements of Principle

Winning.

Suicide will not be addressed effectively in Australia until the community appreciates and is educated about the difference between mental health and mental illness and establishes administrative, management, education and training and service processes that aim to

- recognise that mental health has the same relationship in all respects as the brain has to the body! Without mental health there is no health! And suicide is a mental health/illness issue.
- accept mental health as the pre-eminent force in all human endeavour, recognised, promoted, and identified as the driver of all human enterprise, the 'engine of life', the maker of wellness, the motivator to work, the inducement of the drive to recovery.
- acknowledge that suicide is the ultimate fear in every family where mental illness becomes a resident. That there must be accountability and that suicide in care is the ultimate "adverse event", "critical incident", "sentinel event" in terms of the Open Disclosure Standards and that suicide in care is the ultimate key performance indicator in mental health service delivery and that preventing suicide (death) is the ultimate responsibility of a mental health service.
- ensure that mental health is identified nationally with a unique and distinctive identifier. "Purple for mental health"

Losing.

In contrast alcohol and drugs are a cause of and contributor to disease.
Alcohol and drugs:

- are an illness issue
- are the destructive corrosives in the fuel
- the toxins in the body and the poisons in society
- the makers of illness
- destroy the motivation to work and drive people to destruction

Mental Health has lost its way. Suicide has grown with the increase in alcohol and drugs. Alcohol and drugs administrators have become the designers and managers of mental health policy.

Alcohol and drugs administration and management, clinical support and servicing is a treatment component and is separate and distinct from the overall demands of mental health services with different priorities and requirements. It is a stream within the body of health promotion, care, treatment, and recovery.

Mental health and alcohol and drugs are not compatible. "Mental health" and alcohol and drugs is an oxymoron. Yet in NSW they cohabit in administration and in policy direction. Mental health has been downgraded. In NSW we no longer have "The Centre for Mental Health", we have the Mental Health and Drug and Alcohol 'Office'

Winning.

We cannot address suicide effectively while we confuse mental health and mental illness, and while we combine alcohol and drugs service mentality with mental health promotion, administration, and management. It defeats the purpose. It is like saying that smoking kills but if you have a mental illness it is OK to smoke. Special care facilities are needed but not mingled administration, ideology and identification. Alcohol and drugs is a treatment stream not a human life philosophy.

The analogy. Motor cars, SUV's, utilities etc. all share the same components wheels, tires, computer systems, brake systems, engines, etc. but they are not made on the same assembly line because they all have different characteristics, design features, and assembly processes and particularly, different applications and performance requirements.

State Mental Health Action Hierarchy
(suicide focused)
Specialist Service Streams

Health promotion	Acute care	Community care Home service Community centres Crisis centres family support	Alcohol and drugs	Prevention/intervention activity programs resilience building	Recovery reorientation after-care mediation Open Disclosure

"speranza" is the Italian word for hope.

Executive summary.

1. **Real cases real people.**
   This submission with apologies has adopted a different format to the terms of reference. The Senate might consider how it fits in the national plan. For the purpose of this exercise it is not possible to cover all the issues that need attention but to concentrate on the basics. By reconstructing the services, focusing on suicide as the ultimate adverse event and suicide in care as the key performance indicator, correcting the inappropriate ideology, creating an overall mental health authority (Commissioner) introducing/ensuring accountability, ensuring the absolute implementation-application of Open Disclosure Standards we will be able to lead the way in reducing the incidence of suicide overall.

   When the research acknowledges that up to 94% of all suicides have a diagnosable mental illness it is axiomatic that only by providing more effective mental health care focused on suicide as the key performance indicator will we achieve a healthier community and at the same time dramatically reduce the incidence of suicide inside and outside the service.

   The submission uses the NSW mental health services to a large extent to
   a) present the significance of the relationship between mental health services and suicide.
   b) draw attention to the area of greatest incidence of suicide and attempted suicide and failure of duty of care and the continuum of care and lack of accountability in many of the examples.
   c) address the negative and inappropriate attitudes.
   d) examine the service delivery structure.
   e) illustrate the costs of failure in suicide prevention, suicide in care and attempted suicide and attempted suicide in care.
   f) present SPERANZA member's cases and others as chronological examples in detail (supported by case documentation) to demonstrate where the system is failing and the need for system reform. And proposals for system reform.
   g) use the example of three connected suicides in three weeks (the 3X3 Microcosm) to illustrate the problems of the service in the failure of duty of care and the continuum of care.
   h) illustrate where education and training in suicide ideology is needed including the role of the coroner.
   i) present a more comfortable, acceptable, efficient, time-saving, descriptive and economic terminology in relation to suicide and suicide reporting ie self-aided death SAD.
   j) contest the efficacy of the current suicide risk assessment protocol high, medium and low and propose a better method.
   k) Present a funding model for services and agencies
   l) Consider the needs of the families post suicide, after-care support and mediation and Open Disclosure
   m) The relationship between the disabilities visible and invisible and the need for a united conforming-to-the-need approach.

   A selection of historical documents and recent correspondence is attached to evidence the concerns expressed in this document.

2. **Tony Humphrey & SPERANZA. Business, Mental Health, and Suicide Credentials.**
   This submission is a reflection based on a business background in engineering construction and management and life insurance marketing and company management. Former director 30 bed district hospital. Thirty years experience in mental health agency management and health promotion, 25 years experience in suicide, suicide prevention, intervention, support and recovery. Beginning with the suicide of my daughter Michelle in 1985 at age 23 (carbon monoxide), and experiencing the other end of the spectrum with my son Peter, 'assisted suicide' from melanoma age 49 while in palliative care.

Past chairman and vice president the Mental Health Association NSW, board member Council on the Ageing, mental health organisations including ARAFMI, Mental Health Coordinating Council NSW, the Australian National Association for Mental Health (ANAMH, succeeded by the Mental Health Council of Australia) founder/co-founder three suicide prevention organisations, Australasian Association for Suicide Prevention (AASP), Suicide Prevention Australia (SPA), Australian Mental Health Suicide Consumer Alliance Inc. (Club SPERANZA specialist mental health and suicide prevention advocates supported by a membership of individuals, organisations, and afflicted families). Established the first suicide support groups in 1991. Personally working with hundreds of individuals at risk of suicide and facilitator of hundreds of support groups for people at risk and families bereaved and aggrieved by suicide. Eighteen years working intimately with the State mental health services on major committees and presently an original and continuing member of the Mental Health Acute Care Committee Northern Sydney Central Coast Area Health Service until 20th April 2010.
Currently chairman of SUNSR (Service Users North Shore Ryde) mental health consumer-carer service advisory community committee Northern Sydney Central Coast Area Health Service.

3. Duty of care and the continuum of care. A philosophy of denial.

This submission sets out to show how despite comprehensive written protocols and guidelines and dedicated service providers, large numbers of people (already known clients of the service) are failed in the duty of care (suicide in care and attempted suicide in care) for various reasons including system failure, ignorance, lack of training and education, poorly constructed services, negative and inappropriate attitudes, ministerial and bureaucratic obfuscation and concealment and in some cases, negligence. This ignorance and lack of training in suicide ideology extends throughout the service and associated departments e.g. Attorney General and coroners officers. There are critical errors in system design which leave the vulnerable exposed to the potential for failure. These relates to suicide risk assessments and discharge without affective support and follow up.

4. Not just NSW.

Since the late 80's I travelled extensively and made a study of health and mental health services in the USA, Canada, UK, Greece, Israel, New Zealand and Fiji. Over the last five years at my own expense I have visited the United States extensively to study mental health and suicide prevention activities throughout that country including attending Virginia State Health Department suicide prevention seminar, visiting mental health facilities, services, 'clubhouses' including the headquarters, Fountain House in New York, studying state mental health practices and programs in a number of states, adolescent education and retraining facilities, visiting psychiatric inpatient facilities including Bellevue Hospital New York etc.. In addition I have studied the operation of mental health call centres, support lines, warm lines, and a major private business operation MAP Communications Inc. a company founded by Australians in the US with three call centres (the "front desk" reception for thousands of businesses and eight universities where my daughter is company president).

5. Where is the leadership?

Mental health services in NSW are like a car running on four flat tires. It has been conceded that certainly in Northern Sydney Central Coast Area Health Service (pop. 1.3 million) it is only a "nine to five, five days a week" service (Acute Care Committee). In the early 90s we had Professor Beverly Raphael as an iconic figure who took over the leadership of the Centre for Mental Health in NSW. Since then there has been (until Professor McGorry as Australian of the Year) only a few such leaders to present mental health to the whole community as the pre-eminent force in all human endeavour. Mental health has become submerged in the health hierarchy de-identified and overshadowed by alcohol and drugs, yet where it is almost universally recognised that 20% of the population has the problem to which must be added another 15 to 20% who are their carers. And where mental illness is the second-largest burden of disease in the world today.

The worst feature of mental health administration in NSW is the pedestrian non leadership and unlearned approach and failure of successive ministers to listen to the representations, exercise their authority and responsibility and deal with the issues when evidence of defective management, failure to meet standards, noncompliance with protocols, lack of training, resulting in suicide in care or attempted suicide is presented. In addition to continue to allow the dismantling of community mental health services against best practice professional advice (**The future of community-centred health services in Australia: lessons from the mental health sector.** *Alan Rosen, Roger Gurr, Paul Fanning. Australian Health Review*, 2010, **34**, 106–115) and experience, consumer/carer community and local government objections and overturning decisions already made against this practice. This has allowed a continuation of service failure which in turn allows perpetuation of unacceptable numbers of suicides and suicides in care.

Our personal experience and members tell us that many mental health facilities have been allowed to become rundown decrepit uninviting unwelcoming 'sleazy' and totally unsuitable to be considered as a therapeutic environment and conducive to recovery for people in mental distress, emotionally disturbed or psychotic. In addition there is a shortage of acute care facilities specifically for adolescents necessitating their placement in adult facilities.

6. **Deconstruction of principles.**

Consumer carer community participation in all levels of management became an accepted fundamental in the early 90's and flowered until 2002. However as an example of the dismissal of that principle since 2006, Northern Sydney although retaining some token elements has lost/disbanded the entire consumer carer community participation and advisory groups/committees i.e.

- The seminal Consumer Network established in 1994
- The seminal companion Carers Network established in 2000 (I was the instigator)
- The Mental Health Community Consultative Committee established in 1995 and formalised in 1999, disbanded 2005.
- The last remaining representative advisory committee SUNS of which I am chairman was in danger of being disbanded until reorganised and expanded 2009.

Abandonment of community services and vocational rehabilitation model.

In NSW despite all its rhetoric and proposed new suicide prevention strategy NSW Health Department has ignored commonly understood suicide prevention principles and best practice evidence based mental health principles **(The future of community-centred health services in Australia: lessons from the mental health sector.** ***Alan Rosen, Roger Gurr, Paul Fanning. Australian Health Review*, 2010, 34, 106–115)** and consistently and steadily dismantled community mental health services.

Blatant examples are the retreat to Royal North Shore Hospital of all the mental health services on the lower North Shore, disenfranchising hundreds of consumers and the dismantling of a vocational rehabilitation training program (ShoreWorks) centred on Chatswood displacing around 170 consumers to cut costs and currently with a proposal (which has been suspended) to displace around 150 in the Gladesville/Ryde/Turramurra areas (MARS, CREATE, Cornucopia). In this particular case the suspension and current review came about not because of ministerial responsibility, acknowledgement, intervention and direction, but because of the parental outrage, consumer despair, adverse publicity and letters to the Premier who was obliged to intervene.

7. **You too can relate.**

Real case examples are cited here so that readers can draw out their own associations of ideas and relate humanistically to the subject.

Recommendations Summary

Reorienting the focus.

> ***"When I was young and healthy I wanted to kill myself. Now I am old and unhealthy I am doing everything I can to stay alive - and life is good".***
> Suzane Fabian author of "The Last Taboo" 1986.
>
> Suzane was born in Hungary where she says suicide is endemic. She was a teacher in Victoria and in the latter half of the 80's ignited the debate about suicide in Australia with her seminal work The Last Taboo, about youth suicide. She is now on dialysis three times a week.

Mental health must be given pre-eminent status in the health hierarchy, and promoted with a universal identifier. i.e. "purple for mental health". Mental health must be marketed with a new look. Mental health is about health not illness. Wellness centres (crisis centres) welcoming friendly places to keep people out of hospital. It is about how to get there and how to recover.

1. **Create leadership in mental health administration, identity, and purpose with a single focus. Institute a new positive national recognition program "Suicide and SAD can be prevented".**
2. **Focus on providing services following attempted suicide** i.e. after-care and mediation team support.
3. **Increase the level of recurrent funding to at least 12% of the health budget** so that services and infrastructure can be adequately resourced. **Establish the Life Development Grant and Indemnity Fund.**
4. **Adopt a new commonsense nomenclature Self Aided Death (SAD).** (see Appendix)Focus on preventing the avoidable deaths & self harm not the complication of categorising and coding the cause of death (a created industry of costly and unnecessary diversions).
5. **Establish the independent Office of Commissioner for Mental Health** with complementary state commissioners to extract the contentious processes from the bureaucracy and provide an overview mechanism of examination reporting to Parliament, to ensure that the system runs efficiently and does not review itself. A mechanism and compliance and a review authority to ensure (a) that the principles of Open Disclosure are thoroughly, effectively, and meaningfully applied including the interests of bereaved families. (b) an ongoing surveillance of RCA"s (root cause analysis) and "sentinel reviews" ensuring that recommendations are applicable, take effect and are universally implemented.
6. **Deliver the everyday mobile mental health services from specially designed community mental health centres** in the community including the Clubhouse model and the Minnesota model 72 hour crisis centres "Wellness Centres" (as distinct from PECC units), to provide support in crisis in non-threatening comfortable home-like surroundings, especially facilities for young people.
7. **Introduce Columbia University's TeenScreen.** A broad-based adolescent screening program to identify incipient mental health problems across the whole range, including suicide potential. A young person experiencing a first psychotic episode or mental health problem should not have the expectation that they will have a diagnosis of mental illness to stay with them for the rest of their lives and become a lifetime consumer of mental health services.

8. **Results and reporting to be humanised** and reported/evidenced by numbers/proportions not "rates" of suicide.
9. **Establish a change attitude policy** to stop bad attitudes stigmatising and demeaning people who have attempted suicide and recognise them as having been through a life-threatening event and recovered. A reason for encouragement and pride and looking forward to life.
10. **Introduce the new terminology self aided death (SAD)**

Reconfiguring the System, Structure & Management.

11. **Reconstruct Area Mental Health Services overall** and in Area Health Services into two management streams Acute and Community Services, each with its own director responsible to the Area Director.
12. **Appoint Suicide Prevention Coordinators to each Area.** To be responsible for registering and keeping track of every person admitted to the service following a suicide or self harm attempt to ensure that all their needs are met consistently followed up until they are considered to be at no foreseeable risk but maintained on a routine follow-up contact/support list.
13. **Appoint Area Compliance Managers** to ensure compliance with policy and protocols particularly Root Cause Analysis and sentinel review recommendations and responsibility for ensuring conduct of staff training and critical incident test exercises.
14. **Establish specialist after trauma support teams ATST** to implement Open Disclosure and be the intermediary between the service and the family following suicide and suicide in care.

Promotion/Philosophy

15. **Adopt "purple for mental health" as a universal identifier.** Adopt the SPERANZA Plan including setting up a public campaign to recognise the complementary relationship of the disabilities visible and invisible, promote social inclusion, mental health as the pre-eminent force in all human endeavour, reduce stigma and create pride in the service, by identifying mental health nationally with the colour purple, "purple for mental health". Establish SPERANZA's Hold Out Your Hand model of proven programs.

Ancillary actions.

16. **Undertakes an urgent review over the past three to five** years of suicide in care RCA recommendations, sentinel events attempted suicide in care etc to determine patterns of systemic failure, expose and rectify problems and create a basis for efficient service delivery.
17. **Institute applied suicide intervention skills training (ASIST) and suicide SafeTALK** among all health and allied health workers and among community leaders and concerned parties.
18. **Reconstruct the Risk Assessment Protocol** to crisis, crisis abated, stabilised, and no foreseeable risk.

"Learning to lead the way"

The forgotten ones.

The mentally ill
"are the forgotten people of the 21st century"
Brian Burdekin Sunday Age Dec. 2004

Part I
Understanding the Issues.
The unanswered questions
Open Disclosure:
Transparency, Accountability & Justice

Failure is an opportunity.
If you blame someone else,
there is no end to the blame.

Lao Tzu (c.604 - 531 B.C.)

Suicide is ugly, tearing, painful, cruel, frightening.
Until you rescue and recover the person, then it is beautiful.
Our aim is to eliminate the ugly and multiply the beauty.
Tony Humphrey

Inspiring Hope. An Introduction

Suicide is an issue which always in some dimension creates adverse reactions and even antagonism.

Preventing suicides means working closely intimately consistently reliably with the person without reservation. Sometimes agonisingly often without respite. Many give up. The basis of suicide prevention is the establishment of a symbiotic relationship with the person at risk. In the words of one survivor at one of our seminars it means "getting down and dirty".

The Senate committee has been receiving submissions from a wide range of disparate groups and individuals. A large proportion would be coming from a special interest or personal experience or academic or particular discipline approach.

The fundamental consideration confirmed by many of the submissions and the presentations at public hearings is the relationship between mental health, mental illness, and suicide/self aided death (SAD) and the inspiration of hope in the individual and in the suicide afflicted families.

The consequence is or ought to be, a focus on how we deliver mental health services and how the services fulfill the obligations to duty of care and the continuum of care until recovery is established. There are three important elements in finding solutions;
1. inspiring hope 2. instilling pride 3. creating a universal identifier for mental health.

Duty of care and the continuum of care

Mental health is about health not illness. It is about creating a process to generate health and reduce illness which in turn will reduce the incidence of suicide/self aided death (SAD).

Suicide/self aided death (SAD) has remained undiminished. The expanded incidence of attempted suicide brings huge consequential community, social and economic and personal financial costs.

Health departments, governments, bureaucrats, and academics talk about an "all of government" approach. There are national strategies, national committees, and national councils, state strategies, and state committees.

The old saying "think globally act locally" was never more important. However suicide and SAD prevention/minimisation is not about "all of government", it is about an *all of community* approach, it is about a "whole of population" understanding, a universal philosophy. It is about pride in self, pride in mental health, pride in illness, pride in the service, and pride in having survived a suicide attempt.

This submission argues for global appreciation, new concepts, new interpretations. Using NSW as the example it presents real case examples, circumstances, and events to illustrate the failure to reduce the incidence of suicide/self aided death (SAD). Why there has been a massive failure to protect too many of the people who become bewitched by suicide and admitted to the care of mental health services.

This submission calls for a review of 'suicides in care' in NSW over the preceding three to five years to bring to light the reasons why and patterns of failure that can allow between 100 and 200 people a year who are admitted to the care of the service to kill themselves (and an unknown number to attempt suicide). And why this proportion of avoidable/preventable deaths could have increased so substantially over the last 15 years, to make it the largest of any group of suicides taking in all cultures, all illnesses, all age groups i.e. one third of all suicides?

Understanding the Basics

1. Effective suicide comparisons cannot be made against other countries or states.
2. Suicide prevention inquiries and investigations tend to look for universal strategies. Suicide prevention strategies cannot be directly translated from one country to another or from one state to another although programs and models can be adapted to suit the local circumstances especially where designed to identify the problem and establish a therapeutic connection.
3. Suicide is the ultimate adverse event in mental health services and the ultimate fear in families where mental illness is entrenched and in many cases from first appearance, first episode. "Suicide in care" is the ultimate key performance indicator.
4. Suicide prevention endeavours need to focus on the area where it happens the most where it covers all categories all ages and all cultures to form a "hub" i.e. in the mental health services. Effective properly resourced mental health service delivery will not only reduce the incidence of suicide and suicide attempts overall but will reduce the incidence of homicide and homicide/suicide associated with mental illness.
5. Suicide minimisation should be the primary aim of a mental health service with progressive setting of levels based on numbers not rates. (Numbers represent human beings. Rates represent statistics)

8. The negative mindset within the services e.g. *"not all suicides can be prevented"* (Minister Perry 12th January 2010 letter), *"suicide is a rare event"* (frequent justification comment within the service), *"There will always be those who will do it anyway".* (Assoc. Professor John Allan Chief Psychiatrist NSW Health Suicide Prevention Strategic Directions Forum 15/10/2009) *"he would have done it anyway"* (inappropriate justification to a bereaved family following the suicide of their son while on leave from the unit) must be deliberately and purposely excised from the manuals of discourse and the training material.

9. The mental health services must be specifically restructured to deliver an effective continuum of care in the community and the process of dismantling of community programs and services must be reversed.

10. There must be a new terminology in relation to suicide and self-aided death to avoid the contradictions and inconsistencies in data collection and coroners interpretations so that the public can be educated consistently with a uniform understanding. Australia could lead the way in a new and more realistic approach to addressing and quantifying the problem of suicide and self aided death SAD.

11. Preventing the individual suicide depends on recognising and acknowledging the danger, establishing and maintaining a therapeutic and intellectual relationship with the subject, and creating and maintaining failsafe supports.

12. There must be a mapping/audit project undertaken over recent history of Sentinel Event reviews and RCA recommendations to identify and remedy patterns of system failure. It is axiomatic that if all the recommendations RCAs and sentinel review were observed and implemented the suicides would not be happening to the same level.

13. Accreditation of a service or hospital does not mean 'safety' in health care or protection.

Key issues in this Submission.

Mental health services in NSW an overview.

1. The experience in NSW is applied in this submission to represent the problems and the potential solutions and the relationship between effective mental health service delivery and suicide and self harm minimisation. Although a metropolitan model area health service is given as an example it is not meant to exclude the comparable issues in rural areas.

2. Public political and bureaucratic recognition that suicide is the ultimate avoidable adverse event in mental health services is a sine qua non, and philosophically and in practice must be addressed ideologically in exactly the same human life considerations as any other potentially fatal condition. The unrecognised unreported proportion of suicide attempts and ***suicide attempts in care,*** that result in serious injury and the enormous concomitant economic social and financial costs are a further indication of the need for appropriate services.

3. NSW Health beginning in 2002 has consistently gone against best practice and evidence based professional advice, consumer and carer concerns formally conducted workshops local government working group objections and particularly in Northern Sydney proceeded to dismantle community mental health services and retreat to hospital sites. A process condemned by the professional designers of the previously award-winning services, and dubbed "fortress psychiatry". **The Future of Community Health Services in Australia Alan Rosen, Roger Gurr & Paul Fanning, 2008** (See the separate package of documents attached).

4. Public political and bureaucratic recognition of the need for specifically designed community based mental health services and systems as the predominant approach to suicide minimisation.

5. Effective suicide prevention must focus on mental health and primary care services delivered in the community, while recognising the need for long-term stabilising care and/or immediate access to harmonious but safe facilities for first episode and relapsing individuals.

6. The need to identify incipient problems particularly in young people to ensure the greatest prospect of preventing the advancement of mental illness.

7. The image of mental health services must be re-engineered to become attractive welcoming and supportive. Mental health facilities should be attractive welcoming and non-stigmatising. Admission to a mental health facility or service is frequently but should not be a frightening, fear creating, and ugly experience.

8. Open Disclosure must be practised absolutely with comprehensive post event support.

9. The Vanessa Anderson case and the increase in 'suicides in care' demonstrate that hospital and service accreditation does not mean 'safety' in health care.

10. Universal training participation of all health and allied workers and appropriate community leaders in the Applied Suicide Intervention Skills Training (ASIST) program and Suicide SafeTALK.

11. The level of mental health funding must be substantially increased in the order of 3% to 4% i.e. to 12 to 14% of the Health Budget to equate with the demand.

Defining the Challenges!

To observe and be guided by
the principles of leadership, ownership,
and accountability.

1. Recognising that people make choices in life and death and some choose suicide to meet their needs. And some people with chronic mental illness may choose a lifestyle which sets them apart, which may even alienate them. The challenge is to provide a system which can respect these choices, help them address those created by distorted reality, and for those sinking into a poverty of physical health; to be able to pick them up stabilise/reset their health status and allow them continuation of their choice. As frequently or as often as is required without reservation.

2. Recognising that people with mental health problems and people with physical disabilities share the same problems in the sense they have a temporary or permanent disability and people with mental health problems can have the same high support needs as the severely physically disabled.

3. Affirmation of mental health as the pre-eminent force in all human endeavour

4. Global plans local interventions.

5. Addressing stigma. Establishing a national icon and identifier for mental health i.e. "purple for mental health".

6. Overcoming the negative mindset in the service and suicide in care consequences with clinical staff.

7. Implementing the RCA and sentinel review recommendations.

8. Enforcing training. The philosophy of suicidal ideation.

9. Educating the community. Universal education and training in suicide ideology with service providers Coroners and staff.

10. The mechanics of operations. Restructuring the system. Ensuring compliance with management guidelines protocols and principles.

11. Modernising the terminology. Changing the nomenclature.

12. Understanding the person at risk.

13. Support services; different needs for at risk and bereaved. Providing services that reflect the need.

14. Step up and step down philosophy "release", "discharge", "after care", continuum of care!.

15. A new funding model.

16. Overcoming bureaucratic intransigence obfuscation and obstruction, addressing Health Department misrepresentation.

"The only experts in suicide prevention
are those who have tried it and are still here."
Tony Humphrey

The Failure of Duty of Care & Failed Continuum of Care.

"There will always be those who will do it anyway!"

(John Allen Chief Psychiatrist NSW October 2009)

Phrases like to this evoke a complete desertion of responsibility to a human being, to the ideology, and responsibility to oneself. It is defeatist and it is teaching defeat. We will always have an explanation to justify the bad outcome and avoid admitting mistakes! It makes it easy to cop out. *It is a desertion of responsibility to the family left behind and condemns the family to a lifetime of damaged understanding, a lifetime of emotional penury, emotional desolation, a lifetime even of hate.*

That desolation perpetuates the notion of and potential for suicide in the family. It perpetuates the feeling of desertion by those who are supposed to be by training and education the ones who care.

What they see often is not only has 'God let them down', the professionals that they looked to have let them down.

The Continuum of Care.

Introduction to the care of the service. Care in the community.

Step up and step down philosophy "release", "discharge", "after care", continuum of care!.
At the Senate public hearing in Sydney 3rd March 2010 the Mental Health Coordinating Council and New South Wales Consumer Advisory Group presented a range of statistics illustrating the appalling incidence of suicide after 'release' into the community. This is the failure of ongoing protection in the continuum of care and care in the community.
At a community mental health forum at Canterbury Leagues Club on the 12th of March 2010. The principal presenter Dr Nick O'Connor former director Area Mental Health Northern Sydney Central Coast Area Health Service who oversaw the dismantling of the community mental health services in Northern Sydney stated that the emphasis should be on community services and he would like to see daily support visits to the home.
Introduction to the service means 72 hour crisis centres
Continuum of care means

- after-care on the discharge
- home support
- Open Disclosure special mediation teams post-suicide to avoid conflict, misunderstanding, misinterpretations.

Unanswered questions.
Ministerial silence confirms failure of duty of care.

Questions put by me to the Minister and NSW Health Dept.
Suicide Prevention Strategic Planning Forum audience 15th October 2009.

1. ***Why are the inpatient units continually overcensus with no beds available?***

2. ***Where are the community services? Why are these being dismantled?***

3. ***Where is Open Disclosure? Where is the after death support for the families?***

4. ***Where is the independent reviewing/appeal authority; the Mental Health Commission/Commissioner? Where is the accountability?***

5. ***If one avoidable death of an adolescent girl (Vanessa Anderson) can bring about the Garling Inquiryin NSW how is it that hundreds of avoidable deaths in the mental health services simply become a "low suicide rate", a statistic, and a "rare event"?***

6. ***If we were/are not able to protect these hundreds of people who were already ill what certainty of future can we offer the new and frightened family and the adolescent with the first episode?***

7. ***Why is it that the Minister has "no room in the diary" to meet on these issues?***

- **There has been no answer to these questions and no meeting with the Minister. The forum failed to address the issues.**

- **Similarly waiting on answers to questions put to Dr Richard Matthews. See attachment.**

The largest group of suicides in NSW is in the public mental health services!

"speranza" is the Italian word for hope.

Unanswered questions.

Deputy Director General

Questions for Dr Richard Matthews

MHCC: Forum 10th December 2009

The Premier has announced that because of inpatient pressure in hospitals she is concerned to apply a greater emphasis on care outside hospital.

1. Why are mental health community services being dismantled and particular evidence of this is the relocation of community mental health services at Hercules Street Chatswood to the Royal North Shore Hospital and the proposed relocation of the Cremorne mental health team to RNSH ?
2. Why is this happening against the highest standards of professional advice on best practice mental health service delivery (Rosen et al), community interests, the protests of the Council, community groups, local consumers and carers, and against the decision of a series of professionally facilitated stakeholder workshops attended by all interests and concerned parties with two members of Parliament as observers ending in December 2004, called by a previous Minister (Minister Iemma) to determine the best approach to mental health service delivery on the North Shore. *This decision was to retain, centre, and enhance the lower North Shore services at Hercules Street Chatswood and retain Cremorne Mental Health Centre as a satellite.*
3. Can you confirm that the Cremorne Centre will be closed and sold off on completion of the new building at Royal North Shore Hospital?.
4. Can you confirm that on completion of the new Centre at Hercules Street Chatswood that surplus land will be sold immediately?
5. Can you advise where the money from these sales will be applied?
6. What plans are being put in place to reduce the incidence of suicide in care from one in three to at least the 1995 level of 10%?

Tony Humphrey

President, Club SPERANZA (Australian Mental Health Suicide Consumer Alliance)
Chairman, SUNS (Service Users North Shore)
Member, Mental Health Acute Care Committee Northern Sydney Central Coast Area Health Service

"We are accountable for our decisions in our personal life so why shouldn't we be just as accountable in our work life."
Catherine Pulsifer

Critical Incidents, Sentinel Events, Adverse Events.

Duty of Care, good faith, accountability, Open Disclosure, and support.

With the acknowledged unacceptable proportion of suicides in care it is patent that the service is not equipped ideologically, managerially, physically, and financially to deal with this important issue.

Problem. NSW a problematic state

1. When a person suicides because they have a mental illness they are often variously categorised as cowards, mental defectives, be vilified, condemned and *"they would have done it anyway".* They are often blamed for their actions rather than recognising that they had an illness which brought them to that finality. *"Suicide breaks up families".* **Melissa Sweet "Inside Madness".**
2. Duty of care is the obligation to create failsafe mechanisms to eliminate the critical incidents and adverse events. The continuum of care carries the obligation and responsibility to ensure that the person is protected from self-harm during their associations with the service. "Suicide in care" the ultimate adverse event in mental health, is now recently acknowledged as where the suicide occurs in the inpatient unit or at least within seven days of contact with the health service (although data is collected out to 28 days). This has risen from 10% in 1995 to more than one third at the present time. (Dunsmore J. NALAG Bereaved by Suicide Seminar 19th November 2009). This is the statistic that the health service in New South Wales is now prepared to acknowledge, however when the 'last contact' is extrapolated out to a month it becomes even more alarming. If a person who is known to the service is serious enough to kill themselves and they have not been seen for a month or a week or 48 hours what does that say about the quality and capacity of service support?
3. Failure of the bureaucracy to acknowledge and be accountable for errors defects deficiencies.
4. The not always evident legal consequences of suicide that create problems rather than solutions
5. In 2002 at the same time as the NSW Parliamentary Inquiry into Mental Health SPERANZA established an Open Disclosure support group. This was made up of 29 members of families who were bereaved and aggrieved by suicide and particularly suicide in care. The aim was to establish an open and frank dialogue exchange with the area health service to address the issues from a consumer/carer standpoint and bring about a constructive assessment to try and minimise future suicides. The deputy area director Northern Sydney area health service courageously represented the service at these meetings. Dr. Brian Pezzutti chairman of the Inquiry visited the group during its meetings. The ABC 730 report covered the Inquiry with its documentary entitled Duty of Care which won the Human Rights Television Award for the year. SPERANZA's open disclosure support group and its members was a significant part of the documentary. Following the documentary the area health service withdrew its representative and the Area CEO sent SPERANZA an admonishing letter.

Open Disclosure
Transparency Accountability & Justice

"Open Disclosure refers to open communication when things go wrong in health care."
(Open Disclosure. Dr Dorothy Jones Royal Australasian College of Surgeons Annual Scientific Conference Monday 9 May 2005)

Definition of Open Disclosure.

"The process of open discussion of adverse events that result in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement".
Australian Council for Safety and Quality in Health Care, 2003

Open Disclosure in practice.

University of Technology Sydney has been conducting a research project *"charged with formulating minimal standards or 'indicators' for Open Disclosure. These indicators will enable patients and families, clinicians, as well as health services to determine whether Open Disclosure is conducted in a way that is appropriate and satisfactory for everyone involved."* The project is due to report in June.

Nowhere is Open Disclosure more important than following a suicide in care and attempted suicide in care. Open Disclosure is the ultimate manifestation of transparency and accountability following an adverse event in health care. The most important outcome in the application of open disclosure principles in relation to 'suicide in care' is the achievement of natural justice for the family.
SPERANZA pioneered a movement to achieve Open Disclosure in relation to suicide in care. However suicide in care has not achieved the same status in terms of recognition and accountability as death from any other cause while in care. ***The Vanessa Anderson case resulting in the Garling Inquiry, a supreme example.***

"Meeting the needs of the family is the principal object of Open Disclosure".
(Open Disclosure Research and Indicator Development including the "100 patient stories project". University of Technology Sydney,)
Put simply, Open disclosure is the mediation tool developed to seek a satisfactory reconciliation between the health service and the aggrieved families following an "adverse event" in health care. Its principal aim is to attempt to achieve a reasonable and acceptable resolution of concerns and issues between the service and the families following an adverse event. In respect of this document it is the process of resolution of the issues in the event of the ultimate adverse event in mental health i.e. a suicide in care and its associate attempted suicide in care. Intrinsically by the very nature of its philosophy it acknowledges accountability.

Effectively implemented, Open Disclosure following a suicide in care will inhibit dramatically the potential for suicide perpetuation and traumatising litigation and cost.

Open Disclosure: Basic Principles. (UTS Open Disclosure Research and Indicator Development)

Four principles underpin Open Disclosure: respect, openness, care, and support. These principles are core to how health service staff should treat patients (and families) following a clinical incident.

- Respect: *"Treating people with dignity"*
- Openness: *"You have to be truly open and transparent"*
- Care: *"Truly caring"*
- Support: *"Somebody to clearly say to you this is what you are within your rights to ask and say or to request"*

(SPERANZA comment. In relation to suicide and self harm, at present Open Disclosure is only practiced in the informal sense by the concerned clinicians which denies the very essence of its philosophy i.e. openness and transparency, recognition of failure, immediate expressions of regret and support, accountability and justice for the families, and psychological and financial reparations.)

Without Open Disclosure.

Originally Open Disclosure was intended to deal with ***"adverse events"*** in the hospital environment and the ultimate adverse event in the hospital environment is of course loss of life, however SPERANZA has been able to draw attention to the fact that the ultimate adverse event in mental health is ***"suicide in care"*** and that Open Disclosure can bring enormous benefits to the aggrieved families by providing satisfactory explanations with complete transparency and accountability.

Outcome.

1. When a suicide in care occurs we blame the patient for having an illness that brought the person into care "*he would have done it anyway" "Sooner or later he/she would have been successful"*, it's not our fault! We deny any accountability.
2. Instead of smoothing the path admitting errors offering support, comfort, sympathy emotional and financial reparations, we increase the trauma and stress in the family and the potential for perpetuation. *"Griefs* (and in particular grief from suicide) *can be destructive. It can illuminate the differences, and push people apart as well as bring them closer. The effect of tragic loss can take years, perhaps even lifetimes, to be understood. How many lives have been shaped by the griefs, often unspoken, of their parents or grandparents?* **Melissa Sweet. Inside Madness. p306.**
3. At inquest and inquiry we subject the family to an antagonistic adversarial defence of the failure and blame the patient for having an illness. (3x3 Microcosm). We increase the shame and the stigma.
4. Risk of perpetuation is substantially increased in families with any suicide but is multiplied many times with suicide in care when failed by the system. The service becomes a protagonist in its defence and an antagonist to the families as if it is the fault of the family.

Solution.

1. The need to take an entirely different approach and consider mental illness as a disability. An invisible disability, transient, sporadic, chronic or intermittent or temporarily disabling, but with the same considerations as if it were visible to bring about appropriate action and promote recovery.
2. Promote mental health as the driver of all human enterprise and the difference between mental health and mental illness instead of using the words interchangeably.
   Address these problems through the mechanism of effectively implemented Open Disclosure and the creation of an independent national and complementary state Mental Health Commission similar in structure to New Zealand.
3. Special trained on-call Open Disclosure counselling/mediation team which can respect the post event issues on each side. Suicide "perpetuation" after-care is preferred as being descriptive terminology instead of "postvention" (ugly, jargonistic, meaningless).

"Margaret (Tobin) learnt earlier than most
that life is a perishable gift with an invisible use-by date."
Melissa Sweet. Inside Madness.

Reorienting the Concept of Hope and the Continuum of Care.

The pre-requisite object of all suicide prevention/intervention is to offer HOPE, CARE, PROTECTION, SAFETY, TREATMENT, SUPPORT, and RECOVERY integrated with consumer/carer/family connectivity, and observing and practicing the principles of leadership and accountability,

Reaching for the stars.

1. In Australia the drive to reduce the incidence of suicide has not met with much success. We have learned that where I have been saying suicide has been under reported by about 20% it is in fact conservatively 30 to 40% under reported **(M. Dudley July 2009 NSW Health Suicide Prevention Forum).**

Although we have a national mental health strategy there is,

- no national mental health commissioner to enforce it,
- no state mental health commissioner to complement the national oversight and ensure standards adherence in the states.
- no national standard, ensign, or guidon, as a unifying symbol and rallying point,
- no ongoing public campaign as there is with smoking, cancer, road fatalities, diabetes etc. no common ideal.

"The history of mental health teaches that when reformers dream of a better future, they are reaching for the stars. Translating visions into reality is complex, difficult and unpredictable work. So many variables are involved, there are bound to be failures as well as successes. It is unfortunate that deinstitutionalisation is the one tag that sticks in the community's mind about mental health policies of recent decades. It was only ever meant to be one part of the equation,,,,,,, There has never been the equivalent catchphrase to describe the need for community-based services to provide the full range of people's needs, from the acute and chronic health care to housing, rehabilitation and other support." ,,,,,,, community based services, involving disparate professional groups and the multitude of sectors and layers of government, will never wield the political power of monolithic institutions". **Melissa Sweet. "Inside Madness".**

2. Mental health the driver not the passenger.

The aims and objectives mental health and suicide prevention strategies will come to nothing without (a) effective promotion and community recognition that mental health is not the backseat passenger it is the primary driver of all human enterprise. (b) ability of the service to effectively protect the people who are identified at risk and admitted to care. (c) specially designing and reconstructing the mental health services physically and psychologically to work with people presenting with mental health problems and suicidal ideation. (d) providing protection in crisis and a continuum of care and effective support services in the community for the 'at risk' and (e) for the families following a suicide (and particularly suicide in care),

aftercare support and specialist mediation, Open Disclosure, accountability and a level of compensation to minimise perpetuation and support lifestyle reconstruction.

The challenge for the Senate Inquiry is to bring about meaningful change, in restructuring the system and replacing the negative mindset in the community and in mental health services in relation to their attitude to human life. Reorienting to positive the negative mindset trained into the health services and to create the same status in the value of human life and provide the same level of care for people with mental health/illness issues as is provided for people with other diseases or life-threatening conditions.

A vital comparison of care. A different health problem.

In May 2008 I had a coronary artery bypass. For the time that I was in hospital particularly but also including immediately beforehand and for 12 months afterwards no aspect of attention to my comfort, medication, and treatment was spared. The same consideration is not being shown to people who experience problems within mental health care and particularly when they become suicidal. Although there is worker dedication in the service there is still an uneducated mindset and a bureaucratic indifference, that people who are spasmodically, intensely, or chronically suicidal, can be expendable. This attitude permeates the system. My experience in this respect is largely in New South Wales however "Inside Madness" by Melissa Sweet supports relevance to other states, in particular South Australia. *"One senior health department executive explains his observation that crises involving mental health patients do not receive the same weight of bureaucratic or political concern as crises involving other patients. 'It's partly because of discriminatory attitudes. The patients aren't seen as being as important as other patients. Someone can be waiting for six hours in an emergency department and it's a scandal than a mental health patient in an acute crisis waiting for four days'".* Melissa Sweet. Inside Madness.

To support this contention we only have to look at the examples in this submission and the initiation of the Garling Inquiry which came about from the avoidable death of one adolescent girl Vanessa Anderson. *"It seems that little has changed since 1993, when Human Rights Commissioner Burdekin wrote of the mentally ill: 'they suffer from widespread systematic discrimination and are constantly denied the rights and services to which they are entitled directed at people affected by mental illness is the major barrier to their full and equal enjoyment of life creating a fear and isolation when people are most in need of tolerance and understanding'".* **Melissa Sweet. Inside Madness.**

3. **Avoidable deaths (suicide in care) don't count.**

In NSW there are around 150 - 200 avoidable deaths (suicides in care) each year i.e. one in three of the suicides in New South Wales, increased from one in 10 in 1995 when I requested the seminal study. Instead of being counted as human beings these avoidable deaths are undisclosed, frequently discounted and dismissed in the bureaucracy and are merely a statistic, a "rare event"! As an outcome of the Garling Inquiry Professor Carol Pollock chaired

a committee to redesign the acute care structure. There is no mental health representative on the board of governance there is no mental health stream of acute care.

4. **Suicide, the raison d'être .**

The Fourth National Mental Health Plan incorporates recognition of the service delivery principles that are essential to ameliorate the incidence of suicide across Australia. In particular these are (a) social inclusion, and primary care and specialist mental health services in the community, and enhancing consumer choice. (b) It refers to "wrap around" service provision. (c) It refers to the education and training of "front-line" and allied health workers in suicide prevention and "improving efforts to identify people at risk of suicide". The Plan continues to represent the best principles in the mental health service delivery as have previous plans. However unless we have the prevention of the avoidable death (suicide) as the ultimate raison d'être for a mental health service as is death from any other potentially fatal illness e.g. cancer, we will not achieve any significant reduction in the numbers of suicide.

5. **Deconstruction of community services.**

To reverse the dismantling of community mental health services which in NSW have been substantially demolished since 2000 and a particular example is in Northern Sydney Central Coast Area Health Service on the lower North Shore, (see attachment Questions put to Dr Richard Matthews) but it has happened in Western Sydney and Central Sydney as well. Suicides in care in NSCCAHS are now running at an average of three per month.

6. **Reconstructing for efficiency, to meet the needs.**

State Mental Health Action Hierarchy

(suicide focused)

Specialist Service Streams

Health promotion	Acute care	Community care	Alcohol and drugs	Prevention/intervention	Recovery
		Home service		activity programs	reorientation
		Community centres		resilience building	after-care
		Crisis centres			mediation
		family support			Open Disclosure

To reconstruct the area mental health services into a more effective and efficient operation with two basic streams i.e. acute care and community care.

7. **Accountability and responsibility.**

To ensure that the principles of accountability and the Open Disclosure Standards are implemented in all cases absolutely, and particularly following the ultimate avoidable adverse event in mental health i.e. suicide in care.

"Learning to lead the way"

Part II

How have we failed the needy?
20 years of disintegration.
Where is the accountability?
The bigger issue; attempted suicide.

One third of the total suicides in NSW across the state happen with people we already know!
This group encompasses all ages, all cultures, all health issues .
It has grown from10% in 1995 to 35% - 40%.

Failing the needy. The Costs.

Suicide is *"everybody's business"* we say. We profess to be concerned about "mental health" and suicide but the facts belie the rhetoric. We quote the horror and the statistics but we don't provide sufficient resources financial, human, and material. We don't provide generous appropriate training specific to suicide prevention and intervention. We don't give proper recognition to the need. We don't provide massive emotional support and financial and material reparations to aggrieved families following "suicide in care" to reduce the risk of perpetuation. Instead we oblige them to tolerate an antagonistic adversarial defence by the service and suffer legal expense in their search for explanations. We obfuscate and duck for cover when service deficiencies are pointed out.

When professionalism is challenged we claim privilege and seek immunity and legal protection to evade inspection. We cut dismantle and withdraw community services. We don't promote pride in the service. We don't promote pride in people who have attempted suicide as having been through a life-threatening event and survived as we would with any other life-threatening disease or event.

We fail to observe principles of leadership, accountability and responsibility, service above self. We cultivate an environment of blame and where human life can be presented as expendable if we might be seen to have failed. With no other cause of death do we blame the patient for having an illness and adopt a laisser faire attitude *"he would have done it anyway", "sooner or later they will succeed". "There will always be those who will do it anyway".* **(Assoc. Professor John Allan Chief Psychiatrist NSW Health Suicide Prevention Strategic Directions Forum 15/10/2009)**

Worse still we defend the indefensible and instead of explanations resort to platitudes *"not all suicides can be prevented"* ***(Minister Perry 12/1/2010)***

The Cost of Suicide.

"I expected to die. I didn't expect to wake up in intensive care".
"Moment of Choice" Tony Humphrey

The cost of failed suicide (attempted suicide).

Comparing the value of human life. The relevance to this submission

1. In my book Moment of Choice 1993 (unpublished) I considered attempts and completions and the real cost to the community. The confirmation of my sense of deja vu is extraordinary on reading this manuscript today.

   The following are excerpts from the manuscript. " Professor Beverley Raphael estimated (conservatively) in 1992 the cost of suicide in QLD per year was $40 million. She noted that 25% to 40% of suicides indicated earlier attempts. Professor Raphael said *"evidence as to the cost to health care systems, from suicide attempts, personally in its affects on individuals and families and to communities is not available, but had to be added to the cost of psychological problems experienced by families bereaved by suicide".*
   Suicide attempts are frequently regarded as superficial, not real, because they involve "only" cutting the wrists. Even with a critical overdose as with 'Susie' (case example in the book) attempts were not considered genuine. To the person though they are deadly serious.
   A quote by a teenager on the "Donahue" Program Channel 10, 19th May 1993 "Why Suicide"?, *"I expected to die. I didn't expect to wake up in intensive care".* Death is the positive.

The after costs. The after costs of attempts can be huge and concealed within the general hospital budget requiring ongoing care, micro, thoracic, orthopaedic, plastic and other forms of surgical repair and reconstruction, in addition to the physiotherapy of all kinds.
Many attempts leave serious accompanying lifetime injury e.g. brain damage, amputations, burns, gunshot wounds, and other major problems. For example hand and arm surgery. One major Sydney hospital estimates that it gets 28 to 30 cases a year where reconstruction of nerves and tendons with microsurgery is necessary over many months to regain not always completely loss of function of hands and fingers.

"Unrecorded unidentified attempts only, are costing this country an estimated minimum of $328 million per year(1995 dollars) for direct hospitalisation alone. The prevailing philosophy of "they don't really mean it" giving way to waiting for actual hospitalisation is counter preventative and is like trying to reduce car accident injuries by fitting safety belts without buckles. The more obvious costs to the public health system of six attempts by 'Susie' are estimated at between $25,000 and $45,000 (1995 dollars) . These relate mostly to intensive care and inpatient support following the attempts"

"Acknowledgement of the reality of the attempt, early response and community support could have been expected to avoid most of these costs". ***"Moment of Choice" Tony Humphrey***

A new dimension. The relevance of attempted suicide.

Accurate figures of suicide in care and of the suicide attempts which end up in intensive care units of hospitals are not readily available. At the time there were at least three other post attempt patients besides Suzie in the same ward at the same time, two with severe injuries to spine and/or limbs. In the same hospital (Manly) a few days earlier a young man had died after several days in intensive care. His intellectual future at least would have been in doubt had he survived.

It would seem reasonable to insist on that ground alone in, that no effort be spared to put in place in the community effective mechanisms of support assistance and intervention."

Attempts versus completions.

Below are estimates of the cost of suicide attempts over all. These are based on various estimates of the number of attempts against completed suicide as assessed by a number of specialists in the study of suicide, or on figures supplied to the four Corners program 1993 by those specialists.

	Low	High
Appleby & Condonis 1991	**30**	**100**
Raphael 1992	**30**	**40**
Suicide Taskforce 1992	**50**	**150**
Kosky 1987	**Up to**	**200**
NSW Crisis team study 1993	**Up to**	**700**
Average of high estimates		**238**

ABC Four Corners program 1993 Australia total 300 to 600 per day!

An estimation of the cost of attempted suicide.

If we take the highest of the low figures ie 50 and propose that of those 30 required two days emergency department/intensive care at $8,000 per day at 2010 dollars it amounts to $11,040,000 for direct immediate hospitalisation. If the attempts then actually extend to a period of inpatient treatment of weeks, or with severe injury and lasting disability then the costs are dramatically higher.

2. NSW Health in its submission to the Inquiry No. 88 admits that a large cohort of people at risk of suicide does not come into contact with the mental health system. But makes no

mention of the proportion that does, or the incidence of suicide in that group or the steps taken to combat the unacceptable increase in numbers and failure to protect those in care.

3. The submission attempts to illustrate the cost of suicide in financial terms on various bases. Curiously it does not use any Australian or NSW data and quotes a New Zealand study that estimates the economic costs on 2002 values at NZ $448,250 per suicide. The economic cost of attempted suicide NZ $6,350 per attempt!

4. By comparison WorkCover provides a maximum death cover benefit of $425,000. If human life in terms of suicide in care was valued in the same way as death in the workplace the direct compensation for avoidable deaths in care if it were to be accepted adds up to as much as $106,000,000 per year. So that instead of blaming the patient for having an illness and they would have done it anyway, should we not establish an insurance fund to provide compensation and/or invest those funds in a reconstructed system and ideology to work more realistically to prevent those avoidable deaths.

5. On this basis if SPERANZA saved two lives per year it would fund its services 1 1/2 times.

Unforeseen consequences of failed attempts.

The forgotten case of Angus Rigg

Three million dollars plus legal costs and hospitalisation.

In NSW during 1992 several young men attempted suicide in police custody, some succeeded outright, one died after several days in intensive care. Another, a petty criminal named Angus Rigg attempted suicide in Milton NSW police station. The police officers attempted to revive him to save his life. He had previously made an attempt on more than one occasion in other lock-ups. His last attempt left him substantially brain-damaged, an incomplete deformed body totally dependent on others for the rest of his life.

The incident brought about a massive upheaval in police administration (Suicide risk assessment procedures [Self Harm Policy] of persons in police custody) and of his life; unable to communicate even if the brain function is there. The Police Commissioner and a Minister of the Crown were the subject of a massive public inquiry.

Much was made of the personal failings and unworthiness of Rigg in the media comment. However could it really be imagined that he would have wanted not to succeed and survive as he is now as only a vestigial a human being? Would it really be worth the risk of not succeeding and to be left in that state? Was Rigg attention seeking or in absolute despair at being in the same situation again?

Few if any examples of failed suicide attempts would ever reach the level of community concern the way that of Angus Rigg was brought to the light of public attention. But at the same time it forcibly brings home an even more ugly and heart rending consequence of suicidal action than even the death of the person; the un-considered an unforeseen consequences of not succeeding.

There are many who survive with terrible and permanent injury. There is no evidence that such publicity as that given to Rigg would act as a deterrent similarly as with the debate about capital punishment. Would it mean selection of a more lethal method to ensure success or would it in the end simply be forgotten?

The economic cost.

The case of Angus Rigg puts in view as under a magnifying glass the economic costs of suicide attempts individually as well as collectively, running as this one does into millions of dollars of public funds. Failed attempts almost invariably carry a heavy economic and financial cost as well as a physical cost. They can be the high rollers in the suicide stakes.

"Moment of Choice" 1992 Manuscript.

Suicide in Care in NSW

From 10% in 1995 to 35% – 40% in 2010

Fifteen years of system failures

"If the sad death of one adolescent can generate a major inquiry
why does the suicide in care of *sixty eight* Northern Sydney consumer clients over four years,
including 11 inpatient suicides, (an average of 17 per year preventable deaths)
pass without a whisper?"
Tony Humphrey Submission to the Garling Inquiry

Illustrative cases 1995 - 2010

1. **Karlin Monaghan.** The beginning in 1995. When suicide in care was at 10%.

2. **"And my son is dead".** (SPERANZA member) Five years later. The same service.

3. **"Edith".** Another Karlin ten years later. The same hospital.

4. **The Story of Kerrie.** (SPERANZA member) A 20 year history and universal example of abuse and professional service abandonment, rescued and recovering because of SPERANZA's involvement.

5. **"Stan"** 2007 (SPERANZA family member) Justifying the failure. Blaming the patient, the John Allan (Chief Psychiatrist) proposition, ***"there will always be those who will do it anyway",*** and ***"he would have done it anyway".***

6. **"Adrian"** 2009 (SPERANZA family member) Contemporary failure. The non-person. ***When suicide in care has now reached 35% - 40% and growing.***

7. ***"The 3x3 Microcosm" A Suicide Trilogy.*** *(SPERANZA family members)* An illustration of operational failure of duty of care and continuum of care. One local service. Three suicides A, B, C, within three weeks. ***Three suicides in three weeks all with a connection but not a "cluster".***

These cases are chronologically spaced to illustrate the progression.

See the individual descriptions.

"Learning to lead the way"

"To speak for the dead and offer hope to the living"

To give meaning to their lives, that they didn't die in vain.

1995 The beginning of the story.

Karlin Monaghan & Family

Let their deaths be an inspiration for hope.
Not just a memorial to failure!

In 1995 Karlin was a young attractive woman already embarked on a promising career as a model. She was admitted to Hornsby Hospital for treatment for depression. Karlin was able to walk out of the hospital and suicide under a train. The stress on the family was huge. Two and a half years later in October 1998 the family was awarded $750,000 out-of-court settlement. In December the father died. **The following March the mother and brother together hanged themselves in the family garage** (obviously the money had no meaning).

(reported in Hornsby Advocate)

One example - the complete compendium of failure.

Pre Event

- Personal and protective system failure

Post event

- No family support (pre Open Disclosure)
- Post event family stress and trauma
- Extended aggravated stress from litigation
- Psychological and financial costs
- Meaningless outcome from settlement
- Perpetuation of suicide in the family
- Incapacity/inability of the service to understand/appreciate/address all the problems/issues

"speranza" is the Italian word for *hope.*

Suicide Prevention Education Research Australia & New Zealand Action.

"Learning to lead the way"

Another chapter five years on.

Sharing the pain! Who could forget?

"and my son is dead!"

..... is the anguished cry that burst out to the medical officers in my presence and in the presence of the patient support officer in mediation, from the mother of a young man with a history of instability who shot himself after being allowed to go home from hospital following surgery to his wrists. There had been a previous meeting at a lower level which was extremely unsympathetic and resulted in the meeting with the top executive. The son had been transferred from St. Vincents Hospital as being at risk. And when the mandatory follow-up interview with the mental health services within 24 hours was sought by his father next day he was told he could not be seen for a week. There was further confusion about where the lad was living and when contact was made the day before his death he was "assessed over the phone". He was able to go rabbit shooting with a friend who gave him an unlicensed rifle belonging to his father.

The mother told the interviewers that the Emergency Department psychiatrist could not have examined her son according to his statement because he spoke to him for the first time just before the family all walked out together, there was no appropriate attention afterwards

"and my son is dead"!

"speranza" is the Italian word for *hope.*

Suicide Prevention Education Research Australia & New Zealand Action.

"Learning to Lead the way"

Another chapter.

The unlearned lessons.

2005 "Edith"

10 years on from Karlin Monaghan.

"Edith", a young woman (30's) with a history of two previous suicide attempts. She was able to walk out of Hornsby Hospital and suicide. She had left a long letter setting out her intentions and found afterwards. The psychiatric registrar noted that her observation level should be increased and this did not happen. The system itself was poorly structured, but in addition the open door policy meant that people were freely able to walk in and out of the hospital without being checked. (Some months previously, a young man was returned from leave by his mother who saw him enter the hospital in the early evening. She was contacted at about three o'clock in the morning by the police and informed that her son had been found dead on a train at Cabramatta.) The external sentinel review made a number of recommendations including that the "open door" policy should be changed. It also brought to light that there was no standardisation in observation levels across the hospitals in the Area and it was found that in respect of two hospitals the observation levels were the same but reversed. It took five months to implement the recommendations of the report. Obviously the flawed systems were a large contributor to the failure to protect.

"speranza" is the Italian word for *hope.*

Suicide Prevention Education Research Australia & New Zealand Action.

"Learning to Lead the way"

Another chapter
Abused, discarded, lost, rescued, renewed.
The story of Kerrie. The story of hope

"Kerrie" was 31, (now 34) borderline personality diagnosis and MPD. History of family child sexual abuse from two and a half to eight and a half, state ward, adolescent abuse and rape. Virtually discarded by the service as untreatable. Numerous hospitalisations and continually poorly treated. Many suicide attempts over the years. On a number of occasions and expediently had to be admitted to an out of Area hospital to receive proper attention. There were continuing "demarcation" ownership problems across Area boundaries which worked against the patient's interests. A HCCC inquiry was sought via the Minister but this did not happen. A ministerial review was finally conducted but it applied only to two months and did not include the most serious of the incidents where she was failed by the service again and again with police involvement, and significantly was rescued from having poured petrol on herself to self immolate. On two occasions it was necessary to intervene and contact the service from the United States. "Kerrie" now lives in Queensland and is receiving the kind of attention that has seen substantial elimination of symptoms to the extent that she is now being admitted to University and is employed. Her story was the centerpiece of SPERANZA submissions to the Senate and Garling Inquiries under her real name.

"speranza" is the Italian word for *hope.*

Suicide Prevention Education Research Australia & New Zealand Action.

"Learning to lead the way"

A further chapter

The false premise. Blaming the sick. A misconception perpetuated.

"He would have done it anyway"

"Stan" Suicide "C" The 3x3 Suicide Michrocosm

A family destroyed. The justification!

Why should an aggrieved and bereaved and excellent family have to pay out $8,000 for legal representation at the inquest of their son in an endeavour to get human regard and an explanation of service/system failure. In 2007 they believe that their son was safe and supervised in hospital. The son was a man with a long history of mental illness and suicide attempts. *He was affected by the magistrate's judgment that he should be detained in the hospital for a further two weeks and the fact that his friend had suicided the previous week. He was considered to be in a calmer state of mind despite this knowledge (the Suicide Risk Assessment and Management Protocols for Inpatient Units 2004, specifically warns about this phenomenon).* At about 1745 he left the hospital after asking for and being granted one hour unaccompanied leave. At about 1820 he was witnessed climbing over the wall from the same bridge which he was known to have previously inspected some weeks earlier. The hospital staff phoned the police about 2030 when he had not returned.

The comment to the family later, *"he would have done it anyway".*

The compendium of failure

Pre Event

- *Ignoring or ignorant of the protocol*
- *Personal and protective system failure*
- *Lack of training*

Post Event

- No family support. Failure to implement Open Disclosure.
- Post event family stress and trauma
- Psychological and financial costs
- Incapacity/inability of the service to understand/appreciate/address all the problems/issues
- Irretrievable blame on the patient, lack of accountability, and antagonistic emotionally destructive legalistic defence of failure instead of cooperative constructive resolution. ***Illustrating not what was done, but what was not done!***

"Learning to lead the way"

A further chapter

Total system failure

"Have you any idea how the staff are affected"

"Adrian"

A family destroyed. A future denied!

Adrian was a 23-year-old experiencing his first psychotic episode. He was sent home from hospital when the parents sought admission. He was extremely conscious of the fact that he was not safe. His mother is a former mental health nurse who the next day pleaded for him to be admitted. That night in the hospital he hanged himself with his own belt and he was also found to have cut himself with a razor blade. He was kept on ineffectual life support for three days.

The comment to the family afterwards

"have you any idea how the staff are affected?"

The compendium of failure

Pre Event

- Induction ignorance protocol failures
- Personal and protective system failure
- Lack of training

Post Event

- Incapacity/inability of the service to understand/appreciate/address all the problems/issues
- Lack of professional understanding and effective mediation and realistic family support
- Post event family stress and trauma
- Psychological and immediate and ongoing financial costs
- Irretrievable blame on the patient
- Failure to implement Open Disclosure.

"The 3 x 3 Microcosm of Failure"

One local service.
Three suicides A, B, C, within three weeks.

The Picture.

Three men A B C. Three suicides within three weeks all connected by chronological proximity and admissions to the same service and the same inpatient unit and with two personally known to each other. The mother of B was told by the Attorney General that her son's death was an 'anomaly'.

Curiously, coincidentally A & C had the same first name. Their mothers have the same first name.

1. A died within a few days of discharge from the same unit where C was admitted around 10 days later. B was in ongoing "community" care of the service in the same local area and had previously been a patient in the same inpatient unit. B was obviously visibly a sick person who needed care. He had been taken to the hospital by his mother concerned about his sick mental and physical condition characterised by his unkempt state and his squalid home living circumstances. He was not admitted and returned home. He jumped from his block of units soon after. B and C were personal friends and had lived together previously and were musicians. C was distressed by the death of his friend B the week before.

2. A and C were the same age, B was about 14 years older. These deaths occurred within a three week period in September/October 2007.

3. C was known to have inspected the bridge where he died prior to his death; the same bridge adjacent to where A had hanged himself three weeks previously. C asked for and was given one hour unaccompanied leave from the inpatient unit a week after being told that his friend B had died. He walked straight to the bridge and jumped and was witnessed by a passing motorist.

The Microcosm.

This set of suicides in the one stark example illustrates in microcosm:

- The failure of duty of care leading to suicide in care, including the lack of leadership, lack of training and lack of follow-up support (continuum of care).
- Failure to observe principles of accountability.
- Failure to observe or ignorance of guidelines and protocol,
- The creation of an adversarial relationship between the service and the aggrieved family elevating the potential for suicide perpetuation.
- The failure to apply effectively the principles of Open Disclosure in support of the families.

The Common Thread.

The statements from the parents of A, B, and C and the coroner's documents reveal a common thread;

- lack of professionalism,
- disinterest in the carers/parent's concerns prior to and following the death.
- failure to provide proper follow-up support. (continuum of care)
- in the case of C failure to take into account and analyse seven items of extraordinarily inadequate and deficient documentation of patient records (set out in a report from an independent psychiatrist)
- failure to note the non-compliance with or lack of awareness of a critical warning of the potential for suicide **(Suicide Risk Assessment & Management Protocols: Mental Health In-Patient Unit NSW Health 2004 p6)**
- no risk assessment conducted on the day of the death or to justify the decision to grant leave.
- lack of training in specific suicide ideology and applied suicide intervention skills training.
- what appears to be the possibility that a separate "form" of notes was introduced after the event to provide evidence (otherwise missing), of a change of observation level,

The "multiple injuries" not suicide finding.

The coroner's findings in the case of B and C were death by "multiple injuries" (not suicide) and no accountability. The family of C paid a substantial amount $8000 for legal representation at the inquest seeking explanations.

The same inpatient unit two years later. The continuance.

In September 2009 a four page complaint about unsatisfactory leave conditions-notifications and recording of leave arrangements was made to the management of the same unit by the parents of a patient. They set out in detail the occasions when they had not been able to establish that their son was safe. They proposed rectifying methods of protocol and procedure.

In the official response an acknowledgement was made that there was no effective procedure, accepted and proposed for implementation recommendations for change, and apologised to the parents for the distress caused. In subsequent conversations the parents have stated that they will not allow their son to go back to that unit.

See Attachment 2.
The Coroner's Report Analysis.

"Learning to lead the way"

Part III

Understanding
the Personality of Suicide
Understanding their pain.
The Reasons Why.
The grief experience.

The Personality of Suicide

The Inner Being.

"Pain can be good, like a warm blanket".
Consumer comment.

The Custodial Ideology. Hospitals and prisons.

"This last week I have prepared myself for my last journey into solitude. I was much worse than dead. I was alive"

Excerpt from the suicide note of a gaol inmate.

"I don't know whether to thank you for saving my life
or to be angry with you for not letting me go"

"Suzie" waking after three days in Intensive Care.
(four previous attempts in two months)
Tony Humphrey

"I now have everything that I need
All that is left is the deed
Tired and confused am I
Is it the right time for me to die
Will it feel like I've gone to sleep
Where I will merge into the deep
I have worked out how
So I should have done it by now
but I am scared you see
of how it will be"

Theresa "Miss 23/12" 22/6/96
(Twenty three years to live. Twelve minutes to die)

Left this life three days after her 23rd birthday in 1996

Verses of hope and explanation

aliquam spem habere
(Always be hopeful)

"the hope that leads us oft in dreams

to yearn, to wish, to tread it seems

on distant sand, or shore, or plateau high

or reach and stretch beyond our earthly tie

to fortune sad, or fate unkind; will

if we strive but hard enough, reward us still

with courage in our heart, to flourish and to fill

our latter days with triumph over all past ill"

© **tony humphrey**

THE PERSONALITY OF SUICIDE

suicide has a personality !!!!
a strange, awful, sad, wistful, yearning,
incomprehendable, contradictory, meaningless
quality about it .....
we therefore often psychologically punish
those who attempt and don't complete it,
or in our own mind
we punish those who did,
or ourselves .....
because "we" don't understand .....

© ***Tony Humphrey***

To There and Back.

(The Silent Scream)

When grief and pain the plaintive heart supines
with sadness over gladness it resigns
then failure and its partner gloom descended
oppress and crush the life not even ended.
Until the spark of nascent hope external
reflames the wetted soul eternal,
the joy of life renewed as once believed,
recalled from distant past when faint perceived;
and once again the utter darkness flees
from reborn human spirit that it sees.

Dedicated to those who suffer and suffered the "silent scream"
and in memory of Michelle and Teresa.

© Meniscus 12/92

Attention Seeker

I see the blood, it sobers me.

Why is it so? So that I should
harm myself to do no good.
No good for me for certain sure
to cut and slash my wrists for your
attention, when down inside I really know
that even though the blood may flow
your attitude to me won't go.

You see me as a sham I know.
Who's setting out without real pain
so you then treat me with disdain.
You do not see me deep inside
more torn than even you abide.

You treat me with such cruelty
my sadness and fragility,
you push aside and do not see.
No understanding even brief
from you to melt my secret grief.

You do not seek to find out why,
but simply hurt, oppress, coerce and cry
"wolf". The old, old tale does not apply.
Mine is the pain of soul in stress,
No open wound that you assess
by blood or weal or colour shade
as obvious as it is now made.

I cannot think. No! .... cannot see!
Distress and pain and hurt blind me
till sunken low my offered key
Turns lock, turns heart and then sets free
my awful pallid destiny.

(For James and Suzie and the others.)

© Tony Humphrey

"When"

Uneasy are they who suicide dream
Tortured are those who suicide scheme
Hopeless and lost it fills their scene
Hopeful must we who would intervene

© tony humphrey

"speranza" is the Italian word for hope.

A Contemporary Case.

Where is the continuum of care?
Not well enough at home?
Not unwell enough for admission to care!

A mother (official carer) a practising Registered Nurse
trying to get help writes to local MP ,,,,, 16th March 2010

My daughter has schizophrenia, bipolar disorder, and obsessive compulsive disorder since 1994.

After three years in hospital she has managed to care for herself in a flat provided by Housing over the last 18 months.

Four weeks ago she developed psychosis which has severely reduced her capacity to care to herself. The first symptoms of paranoia leading her to believe other residents in the building were talking about her. On January 22 she rang the police at midnight to accuse a male resident of stealing her bras. She soon became persecuted by the delusion that her food was poisoned and she refused to eat.

She returned to her flat from our home but an hour later came back by taxi because she was frightened.

She was scheduled to be admitted to hospital by a psychiatrist but was told that she would have to return to her flat.

She cannot live there and keeps returning to us by taxi at $18 a time.

She walked home from the hospital after being placed in a cottage with other consumers which she found a frightening environment.

She has tried to enter my house 17 times in two hours. I have tried to get her to stay in our granny flat to adjust to being on her own. One night she walked out at 2:30 a.m. she needed to be sedated to keep safe.

We found that she had walked out of the granny flat and had left the gas on and the flat was full of gas. She switched off the refrigerator and the food was defrosting in the freezer.

She is not capable of looking after herself at the moment. I am a practicing registered nurse and I consider that she is at risk.

The psychiatrist has advised that she is not ill enough to be admitted to hospital!!

Continuum of Care
Too Difficult!

A Consumer (who self harmed by burning herself with cigarettes) writes of her experience two years ago; Excerpt

,,

"I hate that place and many of the staff that work there. It is disgraceful what I went through, and even more disgraceful that nothing was done about it. Even after a complaint was sent to my local MP, as well as to the Health Care Complaints Commission and the director of mental health services in this area, months went by before I heard a response, and even then it was more of a courtesy offer of mediation, rather than any direct action taken."

,,

"I resent the fact that all my disability support pension money goes toward paying for reasonable health care, when it really ought to be putting food into my mouth. I am very reliant on my mother financially, which only serves to reinforce my feelings of inadequacy and helplessness. I was told by the [redacted] Community Mental Health Team that I was better off in the private system, that they would not provide me with a case manager or psychologist because they had already done all they could for me. Funny though that in only a year of private psychiatric care, I have managed to learn distress tolerance, mindfulness, emotion regulation, assertiveness, problem-solving skills, better communication skills and an ability to trust in other people. Pretty good for someone who had supposedly already exhausted all of the resources available from the public mental health system in the [redacted]"

Since this admission a "no smoking" policy has been introduced and a 12 months review of seclusion policy and practice has been instituted.

This person was recently admitted to the same unit in a psychotic state with concern that she was at risk and has now been discharged. I understand that her views are still the same, however she had given up smoking herself and felt that if smoking had still existed in the unit it would have been an inducement to take up smoking again.

Teresa's Story.

"Miss 23/12" 23 years to live 12 minutes to die.

Theresa died by carbon monoxide poisoning when not able to make contact via defective phone. From previous experience she knew that it took 12 minutes to become unconscious.

Her personal statement on life.

I am a 23 year old female who has experienced varying degrees of depression over five years and the last three years I have been in treatment by health professionals. Everyday situations and events seem to have a far greater impact on me and how I feel in comparison with other "normal people". The smallest things can set me off into depressed mood ranging from a slight down feeling to suicidal thoughts and actions. Depression for me can last from hours to days or weeks. The outcome of these feelings cannot be predicted and the method by which they are eased varies greatly too. Depression is very draining, both mentally and physically.
Through my experience of mental health professionals, the methods and techniques which they use can alter depression at least for short periods. Their individual reactions though plays a part in helping and worsening various situations, especially during crisis times.

Generally the help that is available is quite good and overall the system works well for people but this is not always the case.

Some professionals in this field tend to try to rush their clients in speaking or may expect more than can be given in the stage which they are at. Fear of what will be thought of the distressed person is something which can prevent the expression of important thoughts and feelings. Especially if these fears of the health professional for example becoming angry or thinking badly of a person are expressed.

Longer waiting period is to seek help and lacked after our services can result in some people not reaching out to help and can prove to be too long for some people to wait, especially those who are severely depressed and all suicidal,

In many instances there seems to be a large number of services for children but not so much for adults who are equally deserving of help and attention.

It is great that there are a number of discussions on how to deal with those who were experiencing problems will have a mental illness and articles and television programmes can be very informative but action is what is needed. Establishing more groups for various problems and providing well run and decent psychiatric hospitals which are affordable is what is needed. The views on mental illness and psychiatric disorders expressed by the media and using normal television programs can influence the very the way sufferers of these illnesses feel and react. They also can change how other people see the mentally ill, whether good or bad. Activities which are available only to those who are mentally ill or have a psychiatric disorder which are run by mental health professionals could increase self-esteem and be equally found in a safe and understanding environment and this could be a step towards achieving a healthy and happier society. No changes will completely eliminate the problems but they can reduce it and maybe even save a life.

A note left in the car on the night she went missing at Drummoyne.

Written on a page from veterinary surgeon's notepad This was not the night when she died.

TO WHOEVER FINDS THIS NOTE!

As I sit here
The minutes tick away
You don't know how I wish
Wish I could stay

Nothing ever works out right in line
no matter how hard I try
I cannot work it out
I don't know why

the spirit is weak
when it should be strong
I wish I did right
But all I do is wrong

So ashamed am I
It's hard to bear
I feel so bad
It's just not fair

There is an answer
read a book
all they say
you just have to look

therapy was the go
it will be fine
just a few sessions
and happiness is mine
the months pass
it won't be long
a little more
then laughter will be your song

talking is slow
to reach the core
it's not enough
you need more

take a pill
maybe two
wait a while
see what it will do

hospital visits
one, two, three
others failed
hopefully this will help me

a bottle of sleep
blades cutting edge
gas coming through
I should have tried a ledge

Here we go
Do not doubt
Finally
Let it out. P.S. I'M SORRY

The Grief Experience.

Attempts have been made to determine whether the grief experience following a suicide is any more profound than from any other death, for example homicide.

One of our members who lost her son lost all her hair and had to wear a wig. My partner at the time of my daughter's death had not even met her but her periods stopped and ridges developed in her toenails and took a year to grow out.

It may or may not be more profound but it certainly has different characteristics for instance with homicide where the perpetrator can be blamed. Very often with suicide there is no one to blame but the person who is no longer there. Blaming and seeking someone to blame is self-destructive and yet it is often part of the grieving process.

Grief following suicide is much more complex because of the blame factor and legal issues associated with the process which like homicide may go on for years but are not as clear cut. The intensity of the grief experience of the family and the trauma following a suicide and the unmet need for an explanation is that which makes the effective application of Open Disclosure in the event of suicide in care such a critical human demand.

The Grief Equation

With time (the SPERANZA experience) from around the 1998/99 working with people at risk, we begin to appreciate the emotions and the mind workings of those who attempt suicide and we began to recognise that they are the real survivors because they have been there! The term "survivor" was being misapplied. By using it to describe the bereaved we were demeaning and invalidating the existence of the people who were still here after the attempt/s and thus creating a divide in understanding; a separatism that was harmful to both sides. We could see that there was no specific organisation available to them, which could validate the person who was self-harming and at risk of suicide. We wanted to create an opportunity to allow them to feel that there was a hope for a future and recovery instead of a state of just "ongoing existence".

We learned from them about the feelings of those caught in the self-harming lifestyle; of their very often damaged early lives. We learned from them where prevention could have most effect. We learned from them that they could suffer every day; that they were frightened of dying "scared to death"; but worse to go on living! Suicide notes or written down thoughts put it, *"I'm scared of dying but I'm more scared of living (in torment).*

We learned that strangely the hopes and dreams of both sides were not greatly different; that each had experienced great loss or never found anything worthwhile to lose. One young survivor (who had a brutal upbringing) listening to the grieving bereaved said, *"I grieve too, I grieve for my own suicide."* Another, with two suicides in the family and an abused early life said, *"I wish I could feel that emotion for others that they have for me"*. *"Maybe I will be able to find it."*

From the survivor side we learned what those at risk needed, to be able to renew. From the carers we learned of the long term anguish when illness and self-harm is entrenched. From the bereaved we learned how to share the grief without taking sides. We learned from the families that the power of grieving can be applied constructively helping to turn people around.

"Learning to lead the way"

Part IV

Addressing the problems
Reforming the system.
Mental Health the new identity
and national identifier.
"Purple for mental health"
The Life Development Grant
and Indemnity Fund.

The Mental Health Services Model and suicide prevention in NSW.

An inspection of the issues not an inspection of people!

Principles of support. Duty of care and continuum of care.

This submission is;

- **presented to illustrate the reasons why there is a failure of duty of care and the continuum of care and to make recommendations applicable not only to NSW but across the country.**
- **predicated on the the fundamental philosophy that mental health services whether delivered by public or community organisations are the pivotal means of reducing the total incidence of suicide and suicide attempts**.

Suicide is the ultimate fear in every family where there is a mental illness and hence becomes the ultimate "adverse event" "sentinel event" in terms of the Open Disclosure Standards and the ultimate **Key Performance Indicator**.

1. **A quick review.**
   Following de-institutionalisation and creation of the Centre for Mental Health 1991 as the supervising body and ultimate authority in NSW (although without line management responsibility), the Burdekin Inquiry in 1993, exposed major mental health shortcomings throughout Australia. Despite future demands becoming obvious in NSW partly due to the increase in substance abuse the Centre for Mental Health from 1995 failed to provide effective mental health services in the community for two reasons (a) "mental health" continued to be the poor relation in the health hierarchy, continually and consistently underfunded (the lowest funded state in Australia) in the face of the obvious rising demands and (b) a bureaucracy and government unwilling, ignorant, uneducated and oblivious to the needs, and adept at media mastery. *"Much of the focus of the New South Wales health bureaucracy, (Margaret learnt) was on keeping health out of the headlines and avoiding public controversy at all costs"* **Melissa Sweet. "Inside Madness".**

2. **Where was the foresight?**
   The Centre for Mental Health although an iconic facility with an iconic head until her retirement (Professor Raphael) failed to project future demands and engage the political will to meet those demands and make provision for resources financial, material, and human. *"It was not Raphael's style to make uncomfortable waves for her political masters, at least not in a public way. And she was not known for her management or administration skills,,,, "* **Melissa Sweet. Inside Madness.** The consequence was a reversal in progress a steady decline in the ability to provide effective services and a policy of cost-cutting by withdrawal of community services.

   The outcome has been an increase in suicides in care. *"Now that you have fixed the economics and the politics, she (Margaret Tobin) often said, 'what about the patients?'"*. **Melissa Sweet. Inside Madness.**

3. **Diversion of funds.**
   Competition within the service meant that over time mental health funds have been diverted to general health care until supposedly quarantined by regulation in 1997. However there is creative diversion of mental health funds and NSW is still way behind in mental health funding and well below the 12 to 14% recommended as the proportion of the Health Budget that should be applied to mental health.

4. **Mental the health services underdog. Equal recognition and financial parity for mental health.**

I was chairman of the Northern Sydney Area Health Service Mental Health Community Consultative Committee for eight years. The role of this committee was to bring together the consumer, carer, community representatives, police and ambulance to meet formally and work cooperatively with the area health service executive (it was disbanded in 2005 under the guise of restructure, to evade the inspectorial aspect of its operations).

In 1997 in this capacity I undertook a personal survey confidentially among the directors of each state area health service. Each area director was asked to give an estimate of the amount of money above their current budget required to deliver what they considered as best service to meet the needs in their particular area. This was a time when there were seventeen area health services. The area director's combined estimates totalled some $40 million per year. Coincidentally this was the same amount required at the time to bring New South Wales up to the national average. From memory the amount required in Northern Sydney was $5 or $8 million. Professor Marie Bashir who was head of Central Sydney Area Mental Health Service was the only area director who stated that she did not require any extra money.

Following this survey I put together a proposition which was supported by members of the Mental Health Coordinating Council to achieve this increase in funding over three years. A delegation of members of my committee met with the then Health Minister Doctor Andrew Refshauge. The proposal was turned down out of hand with the comment "the government has decided to put its money into child protection".

In 2001 Minister Craig Knowles after meeting with representatives including myself from the Mental Health Association undertook a conducted tour of facilities across Sydney and injected $140 million into the mental health system the largest injection ever. However even that did not take up the slack and match the pace of need or compensate for years of neglect in maintenance and the deterioration of infrastructure.

5. **The dream of suicide prevention.**
The Suicide Prevention Standing Committee in Northern Sydney Area Health Service existed for five years and received reports from project officers and examined de-identified cases (about 80) of actual suicides in care (avoidable deaths) in the area health service. The committee was not set up to accord with the authorities mandated by the Centre for Mental Health i.e. for a committee in each area health service as a specialist body to review the circumstances of each suicide in care in the Area and make recommendations. The committee was not given any powers and simply became an examination, monitoring, and reporting mechanism. Over three years there was no significant reduction in the suicides in care which fluctuated at an average of around 17 per year (now averaging 3 per month as far as I can determine) and the committee was disbanded in 2005.

6. **The Outcome.**
The outcome of this failure to acknowledge the past, recognise the present, and look to the future has been a massive increase in suicide in care across NSW from 10% in 1995 **(Public Health Bulletin Vol. 6 No. 8 August 1995 Centre for Mental Health. J. Chipps et al)** to now 35% to 40%. In human terms this amounts to 100 to 250 avoidable deaths each year in NSW. It means that the largest group of suicides in the state, taking in all cultures, all age groups, all diagnoses, all complicating factors occurs within the arms of the service which is set up to protect them.

7. **Loss of identity.**
In ideologcal terms The Centre for Mental Health has lost its leadership identity and been downgraded and is now merely the "Mental Health and Drug and Alcohol **Office**".

An Area Health Service Model.
Only during business hours!

Mental Illness and Emergency Care Services.
Committee discussion. Personal minute notes indicative of a floundering service.

Discussion.
My questions. What is the difference between weekdays and weekends? What are the priorities? You are telling me there is a difference between how we look after patients during the week and how we look after them at the weekend? Answer. Yes!

Why does the same problem keep happening?

Patient Flow Manager: *"patients are affected by 'housing' (lack of public housing), patient flow recommendations not yet implemented on key initiatives, bad every weekend. Problems with staff at weekends i.e. lack of knowledge, should be 24 hour access!*
Two weeks of complete blockage,,,,, no beds. Alcohol and suicide (primary) reasons for admissions".

Nurse Unit Manager 1: *not accepting people on weekends, problems in intersectoral transfers and management in some sectors if North Shore had as many beds as Central Coast wouldn't have a problem of not admitting.*
***"The service is only a nine to five service Monday to Friday!"**,,, no flying squads,,, on weekends basically an on-call service, problems with nurses, admissions deferred.*

Nurse Unit Manager 2: *"waiting lists (in emergency departments) gazumped by inebriates". Emergency departments determine priorities, numbers determine the action.* (in other words mental health patients are relegated)

Director Clinical Operations: *There is inconsistency across the units on procedures. No procedural guidelines (in some instances).*
We need to look at patterns, why things happen the way they do. People can't be admitted after 2300 (considered *"too disruptive").* Berkhout case in Wagga (young man hanged himself in the Emergency Department after waiting many hours) quoted to illustrate problems and who makes decisions. *Review the way we provide our service.* ***Should be redesigning the way we deliver services and community care. "A big task"***

Consumer Team Leader: argued for "safe environments" and community services His concerns matched in with my proposals submitted on many occasions for 72 hour crisis centres.

"It is not only what we do, but also what we do not do, for which we are accountable."
Moliere

Accountability and Responsibility.

Problem.

"One of Margaret's priorities was to improve the safety of mental health patients by reducing the chances of harm associated with their care…….. But safety had been seen largely as the preserve of hospitals' surgical and medical units - mental health and community care had once more been left behind.
Margaret was determined to change that. Complaints from patients and their families would no longer be casually dismissed. Services would be made accountable for the care they provided and the mistakes they made. Every complaint or critical incident such as a patient's suicide was an opportunity for learning about problems with the system and how improvements might be made. ……. Margaret was outraged when she discovered that a standard response was usually sent when patients and their families wrote letters of complaint to the Department or Minister. What a fucking useless system, she raged to one colleague". **(Melissa Sweet. "Inside Madness")**

1. **Who has the ultimate responsibility for failure?**

   With suicide in care we are talking about the most serious consequence of mental illness, a mounting number of avoidable deaths. In the mental health services in NSW from the Minister down an avoidance of accountability no acceptance of responsibility and defence of failure driven by fear of litigation is a characteristic of the response to avoidable deaths in mental health (suicide in care).

   Although not discounting negligence, inspection of the circumstances reveals in most cases systemic failures and failure to comply with protocol. Suicide in care which is the ultimate avoidable death in mental health terms is also the ultimate manifestation of the need for full implementation of the post event Open Disclosure Standards. Apart from them not maintaining or realistically increasing resources to meet demands, three consecutive ministers and Health Department administration have been given complete documentation in relation to serious incidents with requests for action and to meet to discuss appropriate action without response.

2. **Where is ministerial responsibility/accountability?**

   SPERANZA has been seeking responses from the present NSW Minister on all these listed serious issues since December 2008 and an interview since August 2009 with no response until 12 January 2010 (when "unable to meet") with no reference to the questions. The Minister to her credit instigated a process to create a new suicide prevention strategy for the state. However the forums conducted were reluctant to acknowledge the area where the most suicides occur i.e. in the mental health services, and the Minister is still not prepared to meet and address the questions presented by me at the forum and reiterated in this submission.

3. **Three ministers three denials.**

The case of Kerrie is a particular example of service failure on an ongoing basis with a number of critical incidents but where the person has survived. Complaints with complete documentation setting out the specifics and chronology on this case over a period of six months were made to a previous minister, Minister Burton. They detailed a number of attempts illustrating failure of the service to act appropriately, including the necessity to twice contact the service urgently from the United States in emergencies and culminating in the incident where she had poured petrol on herself and was about to self immolate and was rescued by the police. The police were commended in writing for their intervention.
Ultimately the correspondence specifically requested the Minister to institute a Health Care Complaints Commission inquiry. This did not happen instead a "review" by the Area CEO was undertaken which only covered a period of two months and did not include the most serious incidents.

4. Minister 2 and Minister 3.

On 21st April 2008 Minister Lynch the previous Minister and departmental officers were given detailed information and an interview was sought to discuss these serious issues around the case of Kerrie and the wholesale deconstruction of community mental health services and related concerns and look at how mental health can be best promoted. There was no response. There has been no attempt to resolve these issues which were again presented to the present minister Minister Perry in October 2009 *"to be contemporary in your office"* with full documentation and copies to Health Department administration again seeking a meeting.
The purpose of this entire exercise has been to discuss how SPERANZA's special knowledge might be best utilised. Minister Perry has replied 12th January 2010 acknowledging the value of SPERANZA contribution, but without answering the questions and is still "unable to meet".
On the 15th of February I wrote to the NSW Premier setting out my concerns and I received a reply from the Director-General *"the Premier has taken the opportunity to request her colleague (Minister Perry) to carefully consider your letter".*

Outcome.

Not responding is not being accountable. It leads to wrong directions in suicide prevention strategy, inefficiency in service delivery, lack of faith and confidence in the service and administration and ministerial overview, low morale, no pride in the service or self, costly litigation in defending actions. A continuation of and rising incidence of adverse incidents, suicide in care and consequent perpetuation among aggrieved families.
The cases examples SPERANZA has used here all illustrate the lack of accountability in response to the suicide.

Solution.

Ensure that any complaints are handled expeditiously from ministerial level down. Develop a policy of accountability, transparency and responsibility, ensure the effective implementation of Open Disclosure.

"When you blame others, you give up your power to change."
Dr. Robert Anthony

The Negative Service Mindset.

> ***"There will always be those who will do it anyway".***
> Assoc. Professor John Allan Chief Psychiatrist NSW Health
> NSW Health Suicide Prevention Strategy Forum October 2009

Blaming the patient, promoting expendability!
Preaching the Dogma of Failure and the Doctrine of Inevitability!

1. The Contradiction.

The Chief Psychiatrist is on record promoting recognition of consumer/carer and family expertise when working with clinicians as supremely important in the best interests of the person's recovery. ***However this worthwhile approach is completely contradicted and negated by the damaging negative mindset promoting assertion above.***

2. Leadership not blame.

Let's start at the top. When you have the Chief Psychiatrist of NSW addressing a forum of so called "stakeholders" who are there to develop a suicide prevention strategy for the state saying there will always be those *"who will do it anyway"* it demolishes the whole case for suicide prevention. This is blaming the person who has a problem! Blaming the out-of-control person who has a sickness that we have not been able to cure. It merely advances and perpetuates the misconceptions, denies hope and future, encourages apathy and a philosophy of expendability. It intellectually and in practice discards respect and fortifies disrespect for those fighting their internal demons.

> When you plant lettuce, if it does not grow well, you don't blame the lettuce. You look into the reasons it is not doing well. It may need fertilizer, or more water, or less sun. You never blame the lettuce. Yet if we have problems with our friends or our family, we blame the other person. But if we know how to take care of them, they will grow well, like lettuce. Blaming has no positive effect at all, nor does trying to persuade using reason and arguments. That is my experience. No blame, no reasoning, no argument, just understanding. If you understand, and you show that you understand, you can love, and the situation will change. -
> Thich Nhat Hanhi

To say some of them will do it anyway, trivialises their condition and life itself, it means that we are giving up on them; admitting that we are not competent/capable/available/accessible. It means that we are not getting to their psyche.

Outcome.

1. We know that when we fail it is hard on the associated health workers. But it is a devastating crippling everlasting personal tsunami for the family. The potential for perpetuation is multiplied many times. Instead of saying that we are sorry that we didn't find the way to help them solve the problem, we were not able to find the way, we justify failure. We demean ourselves by saying "*they would have done it anyway".*

2. The coroner in a recent inquest (the case of Stan Suicide C 3x3 Microcosm) in his findings dwelt at length and great detail on the history of the patient's illness, making it the patient's problem (blaming the patient) rather than the failure of the system to protect the patient. Instead of isolating the critical issue and identifying the primary breach of, or ignorance of protocol (Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Unit NSW Health 2004 pages 3 & 6) i.e. the classic warning signs, he pontificated unnecessarily and irrelevantly *"why human beings kill themselves remains without a definitive answer"* and by quoting a historian (a specialist in Britain and Nazi Germany) in the context "what if" there had been a variety of other considerations?

3. *We do know why people kill themselves! Because they have a problem and we haven't been able to resolve their problem. We haven't been able to support them effectively. We haven't understood them, we haven't been there when they needed us, we haven't arranged for them not to be alone. We have not been able to recognise when they were relapsing, or we were not able to or trained to recognise the warning signs!*

Solution.

If we are going to address suicide prevention realistically we must have leaders who say *"we are not prepared to discard people ideologically or in practice".* Leaders who will be consistent *"we will find a way to help them"*. *"We will find the resources, human, financial, and material".* We may have failures along the way but we will not dismiss them. We will not perpetuate the negative approach. If we fail we will be honest but we will be accountable. If we are accountable we will be cautious. We will try harder.

Recommendations.

1. Coroners, magistrates and all mental health staff undergo Applied Suicide Intervention Skills Training and suicide education.
2. Institute a universal in-service mental health policy of mental health leadership and positive promotion to change the negative mindset, focused on suicide as the key performance indicator and preventing the ultimate adverse event i.e. suicide in care and attempted suicide in care.
3. Establish an independent of the service RCA review authority operating under the auspices of a Mental Health Commission.

Reforming mental health services
Reconfiguring the System. Structure & Management

Problem.
1. General. Unwieldy management and structure.

Mental health services in general terms are not constructed and managed in the most appropriate efficient way to address mental illness or effectively reduce the incidence of suicide. In New South Wales mental health is without iconic leadership, there is a 'sink hole' bureaucracy. The area health services are inadequately funded oversized and cumbersome, claim to offer "integrated" acute and community care but are not streamlined in management terms, overburdened with administration, and fractured and diverted in purpose by 'management by committee'. The service falsely uses 'mainstreaming' as justification for dismantling best practice community mental health services and withdrawing them to hospital sites in favour of 'fortress psychiatry' driven by a cost saving bureaucratic acute care mentality. The Future of Community Health Services in Australia Alan Rosen1, Roger Gurr2 & Paul Fanning3, 2008

"Margaret was on a mission to make mental health a priority, not just for the government, the department and those running general hospitals, but also for the community generally. When she heard that Flinders Medical Centre planned to put its new mental health unit at the back of the hospital site, she was quick to force a rethink. This isn't mainstreaming in mental health, she told the hospital CEO. The plans were changed." ("Inside Madness" Melissa Sweet 2006)

The media is constantly calling attention to the lack of resources and need for more funding. Radio 2GB Friday ongoing etc..

1. **Bureaucratic intransigence and administration.**

The late Margaret Tobin was a reformer and a formidable agent for change in NSW, and when she took up her posting as head of services in South Australia, *"just the public service purgatory you have to go through with an inexperienced new government"* she was told. ("Inside Madness" Melissa Sweet Pan McMillan 2006) To a senior executive she e-mailed, *"now we need your wisdom to unblock the constipation"*,,,,,Sweet recalls her comments and notes, *"highly complex change management process ,,,,,,,,,the biggest challenge was to manage the complexity while absorbing the anxiety of politicians, bureaucrats, service directors, her staff, consumers, carers, and the community. The issues included community attitudes and ignorance about mental health the disempowerment of patients and carers, the marginalisation of mental health in the broader health system, late detection and ineffective prevention by the primary healthcare sector and poor integration, skills and confidence in the specialist mental health services". "hospital staff didn't have the skills, confidence or resources to handle patients appropriately she said, and patients deserve better".*

These comments apply equally to NSW at the present time. In a recent discussion with the clinical director of a major mental health hospital service in NSW in relation to the problems of admitting mental health patients via emergency departments it was agreed that nothing had changed in the 10 years since.

From the point of view of an outsider working in a special relationship with the services and coming from a background in other industries as well as mental health NGO administration and services, and working in close relationships with consumers and carers it is apparent that much of the problems and issues identified by Margaret Tobin and revealed by Melissa Sweet still exist and operate to the disadvantage of the service users and individuals identified as at risk of suicide. Melissa is a person who is not only well-qualified academically and journalistically to comment on the system but is also well qualified in understanding suicide and an empathic relationship with the issue through the loss of her brother.

2. **Accreditation doesn't mean safety.**

"However, many people who do understand the concept of accreditation believe, almost certainly incorrectly, that when they see that a facility has been accredited that it equates with an assurance that health care is provided safely, or that the service has implemented an acceptable quality improvement system. **(Core Standards for Health Care Safety Consultation Paper August 2001)**

"There are systemic failures in the delivery of quality inpatient health care to people with a mental illness at Royal North Shore Hospital, despite the efforts of a dedicated staff." (**A. Rivers Submission to Legislative Council Joint Select Committee on the Royal North Shore Hospital #97)**

The Vanessa Anderson avoidable death in itself showed up many shortcomings in the hospital system of that particular hospital and the resulting Garling Inquiry led to a further 106 recommendations in relation to acute care including mental health care across the state.. In Vanessa's case an effective protocol did not exist. (**Legislative Council Joint Select Committee on the Royal North Shore Hospital)**

Outcome.

Most of the client suicides happen in the community obviously from a lack of or ineffective service, lack of coordinated follow-up, lack of capacity. There is a need for an effective and efficient service in the community to keep people out of hospital, yet be able to offer immediate and voluntary as well as involuntary access to safe havens including acute care in crisis or relapse.

Solution.

1. To produce streamlined effective responsible top to bottom management processes, reconstruct Area Mental Health Services into two integrated management streams, Acute and Community Services, each with its own director responsible to the Area Director. This structure provides the opportunity for personnel to be seconded to the other side for specialist training experience and familiarisation without neglecting specialisation.
Rationale. Motor manufacturers integrate their manufacture of cars and SUV's because they share the same parts and systems but they are not made on the same assembly-line. Similarly in effective mental health service delivery the needs of clients in acute care are different to those in the community.
"2.1 Standard setting in other high risk industries"

"We can, and should, be doing better to identify and manage risks and systemic failures in the health care system. There is much we can learn from industries such as aviation, mining and road safety ,,,, **Core Standards for Health Care Safety Consultation Paper August 2001**

2. **It has often been said that we should avoid duplication of services, in fact this is incorrect. If those services are effective they should be duplicated and replicated.**

3. "Step up step down" facilities & services.

People Incorporated Minnesota USA is an example of a nonprofit organisation that serves people with mental illness in the Minneapolis and Saint Paul metro area. Founded in 1969, now operate 41 programs in Hennepin, Ramsey, Anoka, Washington, and Dakota counties, with an annual budget of approximately $23 million (US). Now servicing around 7,000 clients. It operates the full range of community mental health services. It is a community driven non-profit model particularly appropriate to Australia.

Step up. Crisis centres

Most people in crisis will resolve that crisis in comfortable welcoming surroundings within 72 hours sometimes up to a week. A particular model of relevance to suicide prevention in Australia is the "72 hour" crisis centres model (Minnesota) which are not hospitals. A comfortable clinically staffed community located 16 bed unit to help people through a crisis without subjecting them to acute involuntary admission unless they become psychotic.

Step down.

There is much talk about the concept of "halfway houses" for people discharged from hospital. In some circumstances separate alternative short-term accommodation is desirable.

More importantly what people need on discharge from hospital after an episode of mental illness is the same as discharge from hospital from a physical crisis; to feel that they will be returned to a welcoming environment with supportive continuing homecare services and where necessary their home has been freshened up and cleaned and serviced to relieve them of this responsibility and worry and reminder of what brought them to the crisis.

These can all be accommodated in the structure below.

State Mental Health Action Hierarchy

(suicide focused)

Specialist Service Streams

Health promotion	Acute care	Community care Home service Community centres Crisis centres family support	Alcohol and drugs	Prevention/intervention activity programs resilience building	Recovery reorientation after-care mediation Open Disclosure

The Funding Challenge.

Funding the agencies. Compensating the families
The Life Development Grant and Indemnity Fund.

The dual dilemma refers to creating the financial capacity to fund processes to intervene and rescue lives and in the event of suicide to support and compensate the afflicted family and inhibit suicide perpetuation.

To establish the life funding model of establishment and indemnity grants for non-government non-profit community organisations. The SPERANZA model of funding is designed to meet all the circumstances and provide continuance and certainty.

Either side of the equation has to take into account the financial impact in terms of funding; the prevention process before the event and compensating the "victims" for the trauma after the event.

1. **Funding prevention intervention and support.** Non-government organisations specially created to address the incidence of suicide need access to an assured source of funding.
2. **Compensation/Reparation.**
   Victims of homicide can receive victim's compensation. Suicide frequency is five times that of homicide with a similar intense grief experience. When a suicide in care happens willthere is always the consideration of compensation and providing for the immediate expenses. But any attempt to seek compensation through litigation is strenuously resisted by the service and if the families proceed it can be extremely costly in money terms but more importantly in emotional terms. Most families do not feel they can go to these lengths.

   SPERANZA has advocated an immediate ex-gratia payment of $20,000 to each family crushed by suicide in care as a matter of course. If such a gesture was made in each case it would help the family in practical terms without prejudicing any litigation potential. Even for a suicide not classed as a suicide in care the same provision should apply. The question is how can this be provided for?

3. **Addressing both sides of the equation. SPERANZA Proposes.**
   A quarantined insurance and NGO support fund. In addition to a preliminary gesture, if real recognition is to be given to the value of human life in terms of suicide in care in the same way as death in the workplace i.e. $400,000 plus, the compensation for avoidable deaths in care would require a substantial insurance fund.

   Life Development Grant and Indemnity Fund.
   Nationally establish and quarantine an insurance compensation fund of $100 million to be available for families coping with suicide in care and/or invest funds in a reconstructed system and ideology to work more realistically to prevent avoidable deaths.

1. From this fund draw down amounts to fund suicide prevention, education, training, and support programs primarily for non-government organisations, and top up this amount when it drops below $50 million.

2. From the insurance fund with an establishment grant of $1 million, set up the SPERANZA Foundation to raise public funds to distribute financial support for families afflicted and aggrieved by suicide and suicide in care.

Grant & NGO Funding.

Should be applied according to a priority predicated on the capacity to minimise the incidence of suicide.

Priority 1.
Saving lives. Capacity or ability or potential to directly prevent suicide
Public mental health services, not for profit non-government agencies

Priority 2.
Support services
not for profit non-government agencies. Public mental health services,

Priority 3.
Training in specific suicide prevention ideology
Public mental health services, not for profit non-government agencies

Priority 4.
Awareness and education, large scale and/or local, social inclusion
Not for profit non-government agencies, public mental health services

The New Terminology.

The Case for SAD. Self Aided Death.

Suicide interpretations, suicide rates, unreliable data and consequences.

The problem.

What is suicide and what isn't?

1. What we are trying to prevent or minimise is not suicide as strictly defined and where intent can be proven or accepted, but any death as a result of the person's own deliberate actions and any attempt, where their mind and thinking is distorted from reality. The definition of suicide does not accept other circumstances where death occurs directly as a result of the person's own actions and without demonstrated intent. Some extraordinary examples of death determined as "not suicide" include Heath Ledger, and locally Steve Rogers.
    - John Bell the principal and founder of Esprit who was suffering from depression and a failed relationship was found wedged under the seat of his spa, "was not suicide".
    - A man on a CTO in NSW travelled to Western Australia out of the jurisdiction where he was rescued from a high tension tower by the police after five hours in gale-force winds and blazing sun and three days later jumped to his death from the same tower immediately after being released from hospital care. The coroner decided; *and it would be "a comfort to the family", that it wasn't suicide, it was death from "multiple injuries".*
    - A young man walked into Wallsend police station some years ago grabbed a police officer's service revolver shot and wounded a constable. He ran into the street and shot himself in front of his father who was running towards the police station. The coroner decided that it *"was not suicide because he did not have the capacity to form an intent to kill himself because he was under the influence of marijuana."*

2. **Suicide as a social event. The emotional costs/damage**.
   Suicide is violent. Suicide does not bring people together. Suicide causes people to shun the family. Suicide is a sin with some religions. Suicide has become a weapon of violence. Suicide alienates. Suicide divides families, forces people apart to deal with their grief in isolation. Suicide sets up tensions in relationships. Suicide creates denial, rage, guilt, apathy, enmity, disinterest in life, suicide perpetuation, unwillingness to recognise the term and adopt the concept. The word and the notion can become anathema, accentuate the grief, and entrench the distress. Wasn't suicide! *"My son/daughter would not have killed themselves"."must have been an accident".* Michael Hutchence"s brother Rhett now wants to claim that his brother's death was not suicide. His father who was a personal associate of mine accepted it. The concept of death created by the word suicide in the world of the bereaved focuses and perpetuates the thinking.

3. A major proportion of suicides have been the victims of child sexual abuse (35% of women and 15% of boys, mean age of 10 [Raphael B. 1995]) Another reason for denying/hiding the outcome because it exposes the perpetrators, usually within the family.

4. **Suicide as a "cause of death".**
   In data collection suicide is subject to many interpretations by coroners whereby it becomes "not suicide". Skylarking, multiple injuries, *"not have the capacity to form an intent"* (under the influence of drugs), misadventure, could not determine intent, etc. and maybe even to relieve the service of accountability. When we consider the suicide data we report only the suicide part of homicide/suicides. "Suicide" cannot be accurately standardised across Australia or between countries. The recent case "Stan" was not suicide it was "multiple injuries from a fall" (which was the correct and actual cause of death). The fact that "suicide" is under reported by 30 to 40% on a "conservative" basis and that there cannot be any consistency in this classification means (a) data is totally unreliable and (b) should be replaced with a more meaningful, appropriate, useful, universally acceptable, and relative classification.

The outcome.

- **Suicide; the societal and financial costs.** Tuesday 28th July 2009 around 8:30 a.m. a person died under a train at Lindfield. This incident tied up the entire North Shore rail system and some other parts of the system causing inconvenience and hundreds of thousands of dollars. Delays were experienced until 2 p.m. This was probably a suicide. Last year there was a suicide at the next railway station in the same circumstances with similar outcomes (the family was in contact with me). This type of death incident illustrates the invisible costs of suicide. Others for instance are the tying up of emergency services when people jump from buildings or search parties in the wilderness etc .. On top of these obvious costs there are the emotional and consequent financial costs on the witnesses, bystanders, the train drivers, the police, fire, and ambulance personnel.
- When a suicide occurs the financial costs to the family would average around $20,000 taking into account the costs of the funeral (say $10,000) and the long term costs of supporting a family in its state of emotional paralysis for a considerable time afterwards either directly or with support agencies and welfare. The cost of long-term injuries occasioned by failed attempts is enormous and dealt with elsewhere in this submission.
- There are costly delays in making a determination whether it was suicide by definition or not. Complex and unnecessary coding. Expensive legal argument for insurance purposes fighting to prove that it was suicide on the one hand or not suicide on the other. The only determination should be "not homicide" or foul play of some kind. Other categories are unnecessary and for academics and purists.

The Solution.

1. Create a new category embracing all the circumstances. i.e. Self Aided Death SAD. If academia wants to differentiate and select out suicide with intent it can do so. SAD is descriptive non-threatening comforting terminology that in itself relates to the nature of

the event without causing the extreme reactions, and allows more latitude in the mind of those left behind to accommodate this disastrous event. It becomes in itself an implement of support in the bereaved.

Recommendations.

Focus on preventing the avoidable deaths & self harm not the complication of categorising and coding the cause of death (a created industry of costly and unnecessary diversions). Adopt a new commonsense classification Self Aided Death (SAD). (see Appendix)

Practical risk assessment

The illogical impractical suicide risk assessment theory

High medium and low

1. The continuum of care and duty of care is acknowledged to exist out of the hospital by requiring that when a consumer is assessed to be at a level of risk of suicide discharge planning includes the requirement that they must have a follow-up appointment within stated times following discharge according to the level of risk assessed at high, medium or low. There must be a management plan put in place. **(Policy Directive. Discharge planning policy: adult mental health inpatient services. NSW Health 2008 p18 5.2 Suicide Risk Rating & Response)**.

2. *"Prior to appproved leave and inpatient discharge,* ***the suicide risk status of the person must be reassessed to determine whether leave/discharge can be approved at this time"*** **(Policy Directive. Discharge planning policy: adult mental health inpatient services. NSW Health 2008 p18)**.

Qualifying the risk status.
When someone is at risk of suicide *they are at risk*! They are in crisis. There is no high medium and low.
They continue at risk until that crisis itself has abated become stabilised and there is no foreseeable risk. If someone is at risk of suicide they must be in supervised care of some sort.

Criticisms.
The proposition of high risk or any risk of suicide and discharge is an oxymoron and a contradiction in terms.

Over the years however clinician authorities and the Centre for Mental Health have continued to assert a process of denial and justification for an unnatural illogical and plainly absurd concept.

Terms high, medium and low as stated policy cannot possibly equate to the variable mood states and state of mind of a suicidal person and have been dispensed with by recognised authorities.

The Process.
Discharge plan must set out a step by step pathway with a logical sequence of actions and identified markers of progress and association with the client and significant others, with checks and certainty of continued contact. It must assign responsibility throughout the process and service. In this most important area types of service and availability for follow up must be part of the consideration e.g. serial, parallel, integrated, and how to apply and integrate them.

The Risk Rating Admission Discharge and Follow-up Protocol.

To discharge people at risk at any level is an abrogation of responsibility and the right of the individual to be protected and receive proper care and treatment. The process needs;

- to consider how to deal with repeat presentations and the contribution and likelihood of the influence of inappropriate staff attitudes.
- to support a model of staged follow up to relate to the concept of and heading towards recovery.
- to offer support agencies with relevance to the client.

A protocol which is predicated on risk assessments of high, medium and low

- is a flawed unthinking argument and an offence to the vulnerable and the interests of the people at risk and their carers in its failure to provide a workable and efficient process that not only acknowledges but observes duty of care on an ongoing basis.
- offers absurdities as proper process that are an insult to an intelligent reading and responsible examination. It attempts to justify an illogical stand.

The Essential Training

The LivingWorks Applied Suicide Intervention Skills Training ASIST is the foremost evaluated tested proven most effective introductory program. Developed in Canada it has been recognised almost worldwide.

Together with its companion program Suicide SafeTALK it is the recommended simple effective training program of choice to be utilised by professional services and the community alike. There are already in existence many qualified trainers but there is no concerted program only sporadic presentations.

ASIST is a two-day workshop which devotes a lot of time to role-play and addressing inappropriate attitudes in working with people at risk of suicide.

The Importance of Screening.

An essential tool in early intervention and prevention and identification of the potential for suicide things are conveniently is an effective universal readily implemented screening program. The most effective program for screening adolescents is TeenScreen developed by Columbia University USA.

TeenScreen® National Center for Mental Health Checkups at Columbia University

Key Facts about Mental Health Screening and the TeenScreen Program

Mental Health Screening for Youth is Effective

Screening is an accurate predictor of mental health problems that may develop into more serious conditions. In a study examining young adults several years after they had participated in TeenScreen in high school, two-thirds of those who made a later suicide attempt or went on to experience a major depression in young adulthood had been identified as being at risk in high school.[1]

Clinicians in school-based health centers (SBHCs) using screening tools to assess students who present for services correctly identify three times the number of depressed youth, five times the number of anxious youth, and four times the number of youth with multiple disorders as compared to SBHC clinicians who do not use screening tools.[2]

Rates of self-reported suicide attempts decrease when screening is combined with education about suicide and its prevention.[3]

The U.S. Surgeon General has highlighted screening as an effective method of youth suicide prevention.[4, 5]

The President's New Freedom Commission on Mental Health places a high priority on the implementation of voluntary school-based screening programs.[6]

The Mental Health Commissions

1. **"Australia needs a mental health commission" Rosen A. McGorry P. Groom G. Hickie I. et al Australasian Psychiatry Vol. 12 No. 3 September 2004**

At the present time and using NSW as a model there are a number of agencies influencing the delivery of effective mental health services and complaints and reporting. These are government and non-government and include; The Mental Health Review Tribunal, the Health Care Complaints Commission, the Ombudsman, the Guardianship Board, the area health services, and a plethora of non-government agencies.

The establishment of a permanent Mental Health Commission and Commissioner reporting to Parliament independent of the political process is an essential pre-requisite to the delivery of the most reliable complete economical effective mental health services and to ensure effective fully focused, efficient, management of mental health services in NSW.

Such a commission would have a monitoring role and by its very nature help to ensure the pre-eminent place of mental health in the health hierarchy, overview the management and operation of mental health services, ensure timeliness of reporting, compliance with and implementation of Open Disclosure Standards and legislation, and ensure that there is a transparent effective efficient complaints handling process which is independent of the health services themselves by collaborating with the HCCC and the Ombudsman's and Coroner's Office etc.

The need for a commission is demonstrated by the slow or no process for ensuring families rights and concerns, expediting duty of care reviews and complaints, implementation of Open Disclosure in relation to avoidable adverse events in mental health care and particularly suicide in care and attempted suicide in care.

New Zealand has a Mental Health Commissioner and a number of states in the USA have a similar office.

"SPERANZA to lead the way"

SPERANZA is the **unfunded advocate** that has worked with all sides of the issue and represents all parties. See attachment. SPERANZA information kit.

SPERANZA *Advisory Panel*

Garry Blaschke OAM Disabilities specialist. President Disabled Surfers Association
Mary Lou Carter Secretary Carers Alliance. Mental health and disability advocate.
Ted Quan Psychologist Area Health Advisory Councillor, Member Health Care Complaints Commission Past chairman Ethnic Communities Council
Professor Alan Rosen FRANZCP former director Lower North Shore & Royal North Shore Hospital and Ryde Mental Health Services.
Dorothy Smith OAM Action Foundation Mental Health. Consumer vocational & recovery training Past President. Prison population mental health campaigner.
Erdal Vural Service Manager PEIRS Prevention Early Intervention & Recovery Services Western Sydney Area Health Service
Eva Fera Consultant clinical psychologist

The SPERANZA premise;

- rests on the principle of re-empowering, enabling, and restoring the interchange between the consumer, carer, community advocates and the services. So that together they can constructively and collectively address the issues.
- to take into account the flow process from the community through the services to follow-on support functions for all mental health consumers.
- to be united in considering the interests of all those who have disabilities visible and invisible, because we are all part of the same family, and we all share the same issues.
- to be enabling, constructive, and acknowledging.

The SPERANZA Plan
Purple the new national identifier. Hold Out Your Hand.
The SPERANZA Foundation

1. The mental health icon. To develop and promote a new image for mental health by promoting "pink for McGrath and cancer" and "purple for mental health".

2. To promote and develop SPERANZA's Hold Out Your Hand suite of specially designed trialled and proven programs covering the spectrum of needs from identification, intervention, treatment, support, and recovery programs including resilience building and mentoring activities programs for young people and identified consumers, educating and building awareness and training in the community, developing communication and support networks integrated with the mental health services.

3. Through the planned SPERANZA Foundation to raise funds to provide financial support to families bereaved and aggrieved by suicide particularly suicide in care.

"Learning to lead the way"

Part V

Attachments and supporting documents

”The 3 x 3 Suicide Microcosm”

An Analysis of Failure.

The questions arising.

In the knowledge of the two previous suicides A and B how is it possible for the treating teams with C,

- to be so off their guard and
- particularly to act so unprofessionally and ignore the most significant protocol requirement which is at the heart of every suicide prevention training, course, program, education seminar with respect to warning signs (to be on guard with an appearance of sudden improvement?

Suicide A.

Extract . Mother’s parent/carer statement.

My greatest concern in the whole process was my role as carer.. When ,,,,,,,was released, I asked for advice on how to care for him at home, and was told by the registrar to ‘be a mum’.
I was given no interview, I was simply told that my son was ‘better’. (He)actually asked if I had received any advice, and all I could quote to him was ‘Be a mum’. This woefully inadequate piece of advice, and the feelings of guilt which it evokes in me, will be etched in my mind forever. Perhaps there are issues of patient privacy, but I think that if the health of the patient is paramount, the professionals should recognise the carer as a resource, and include them in the circle of patient support.
After ,,,,,,,,’s death, friends including a psychiatric nurse and a clinical psychologist told us that from their experience the time after release was a danger period for patients with suicidal depression. If this information is out there among professionals, we could have been given it, and it could have helped us in supporting …… . Even if there is no specific danger period, the fact that ,,,,,, was possibly still in danger was not transmitted to us.
I found there to be an enormous gap in articulation between inpatient and outpatient care. My son’s first meeting with the case manager was 6 days after release, and there was no psychiatrist at the meeting. This may be adequate for some patients, but given the critical nature of ,,,,,,,’s illness, and the fact that he had been in intensive care for only 3 weeks, it was far too long a period (12 days) before he was scheduled to see a psychiatrist. There was no follow up phone call to our home by the doctors after his release from intensive care.
The meeting with the outpatients’ case manager was very disappointing. The case manager did not follow up in detail on ,,,,,,,,,,,,,’s answer on his state of mind. He said that he felt bad, and the case manager said that a patient’s mental state often deteriorated after release, but gave no suggestions or advice as to what to do about it. The questioning was perfunctory, with little attempt at eye contact, and I did not get a sense of any engagement withmy son. From her answers to,,,,,,,,’s questions it seemed that important information had not been transmitted to her about his case. Although the head of the ward had suggested counselling this was not mentioned. The interview finished with the case manager handing him a card in an impersonal way saying, “Call this number if you feel like self harm’.
I feel that if a psychiatrist had been included in the meeting, the issues would have been addressed in greater depth and with more engagement.
We were given no information on what the ongoing treatment and program would be other than that there would be a meeting with the psychiatrist. I was left with a sense of being set adrift.

Suicide B.

What was learned from the suicide of A? **The coroner found the man had died from “multiple injuries”.**

Suicide C.

What was learned from the suicides of A and B

The coroner found the man had died from “multiple injuries”. There was no analysis of the failure to protect. Only an analysis of the state of mind.

The 3 x 3 Suicide Microcosm.

The Coroner's non analysis and non findings.

The coroner examined the entire medical and mental health life history of the deceased. He examined the effect on the state of mind of the subject following a hearing by the magistrate. He found good reason for legal representation of staff at magistrate's hearings to equalise the consumer representation and reduce the adversarial nature of the hearing. He did not analyse the process issues raised by the independent psychiatrist into the inadequate recording of decisions and support of decisions and state of mind progress notes and failure to conduct and record a suicide risk assessment before the final leave was approved. Such an analysis would help to bring about real system reform. He made no observation that the registrar was ignorant of protocol. With the exception of the independent psychiatrist's report, the staff report and the final summation were taken up with the entire mental health history of the patient rather than the circumstances of the time. This sad recital of his complete history and ongoing suicidal ideation seems to have swamped consideration by the coroner of the actual events and relationships prior to his death which led to a complacency about his actual state of mind and intentions.

The psychiatrist says, " The only formal assessment of clinical risk noted in Mr. ,,,,,,, inpatient file is a notation in the A1 section of the MH-OAT document describing him being at high risk of suicide."

Issues arising.

1. The coroner was completely unlearned about suicide ideology and stated, *"we don't know why people kill themselves".* To the distress of the family he pontificated unnecessarily and irrelevantly and at length about "what if" and quoted a British historian Hugh Trevor-Roper, a specialist in Britain and Nazi Germany!.

2. The coroner to the distress of the family dwelt unnecessarily and irrelevantly for a page and a half on the mental health history of the deceased instead of focusing on the immediate issues. The effect of this was to add blame to the patient for having an illness.

3. The coroner did not analyse the presented areas of failure to protect, and ignored seven expressions of concern by the independent psychiatrist about inadequate progress notes and justification for decisions which referred to concerns about inadequate, insufficient, not present recording of decisions and actions.

4. The coroner did not note two instances indicating the possibility that a separate form was introduced after the event to note the change in observation levels and thereby justify the leave decision?

5. Apparently the coroner was not presented with the glaring example of ignoring the most significant protocol qualification in relation to suicidal patient management and registrar admitted to not having seen the protocol. **In external suicide prevention education and training programs this is the classic warning sign.** (*"Staff need to be alert to an 'apparent improvement' in which a person's affect may suddenly appear calmer. This may be as a result of a decision by the person to carry out suicide plans. This can be misinterpreted by clinicians as a real improvement and lead to a 'lowering of the guard'."*) **(Suicide Risk Assessment & Management Protocols: Mental Health In-Patient Unit NSW Health 2004 p6)** The Registrar admitted that she had not seen the protocol. There was no risk assessment made on the day that leave was granted.

6. In relation to suicide risk assessment commonsense would dictate that it should be undertaken each time leave is being considered. A policy directive to formalise this requirement was put into effect in 2008. *"Prior to appproved leave and inpatient discharge, the suicide risk status of the person must be reassessed to determine whether leave/discharge can be approved at this time"* **(Policy Directive. Discharge planning policy: adult mental health inpatient services. NSW Health 2008 p18)**.

The 3 x 3 Suicide Microcosm.

An independent analysis. The Psychiatrist's Notes. Suicide C.

(expressed concerns about poor procedures and practices)

"OPINION."

,,,,,,,,, the clinicians,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, clearly apprehended the seriousness of his suicidal risk, in particular emphasising the high changeability of Mr,,,,,,,,,,'s mental state"

1. *There is no notification in the Progress Notes of either the fact that Mr ,,,,,,,,,,'s acuity level was changed to Level 4 or that this had been discussed with Dr,,,,,,,, or other consultant psychiatrist. The change to observation level is noted in a separate form in the clinical file. (This is extremely troubling. Combined with all the other incomplete notes it indicates the possibility that this form could have been introduced after the event to support the decision.)*

2. *"Despite this, I have some concerns about the adequacy of documentation in the clinical file pertaining to the last hours of his admission. In particular, it is not clear from the narrative provided in the progress notes what time Mr ,,,,,,,,,'s, acuity level was changed from Level 3 to Level 4 which in retrospect was a critical decision in his suicide.*

3. *There is documentation that the acuity level had been changed but no clinical justification for this decision is noted in the clinical file". (Was this "documentation" to change to observation level that which was noted in the separate file?)*

4. *,,,,,,,, the lack of notation of the effect of this upon Mr.,,,,,,,,, mental state is concerning". There is no notation from nursing or medical staff explaining the rationale for providing Mr. ,,,,,,,,,,, with a 1-hour gate pass of unaccompanied leave.*

5. *,,,,,,,,, however there is no information as to the adequacy of the assessment of his mental state or the degree of risk presented by him leaving the ward unaccompanied".*

6. *"What was not evident from the notes pertaining to Mr ,,,,,,,,,'s admission was the clinical basis on which the risks presented by his mental state was determined at each point of clinical decision-making and in particular how this figured in decisions about leave from the ward".*

7. *",,,,,,,,,,,,,,,,,,,,There is an ongoing system-wide problem of inconsistent documentation of clinical risk in mental health units and the term 'risk assessment' has evolved into having multiple meanings depending on different settings".*

Case Samples Summary

Suicide Potential, Suicide in Care, and System Failure.

This list incorporates cases described earlier.

Recent.

1. A few months ago a young man experiencing a first psychotic episode frightened, and concerned that he was suicidal, was at first sent home from the hospital. His parents (mother a mental health nurse) persevered and he was admitted next day. He hanged himself that night with his own belt. He was also able to cut his wrists in the hospital. After four days in Intensive Care life support was discontinued. Statements from the family.

2. *Two years ago a 60-year-old man with a history of mental illness and previous admissions was admitted to hospital in the afternoon after a previous confrontation with police where he had said "I want to kill myself, I want to die, I need to go to the mental asylum". By 7 pm he had been assessed by the doctor as "not meeting the criteria" and was discharged. There was no service plan constructed for him. There was no attempt to see that he was not left alone. There was no formal follow-up put in place. There was no concern that the man lived alone on the 15th floor of an apartment block. At 9:45 pm the man removed his clothes and jumped from the balcony.* Documentation sighted.

3. *Recently a mother who was experiencing problems with her son was so overwhelmed with the failure to get effective treatment for him that she felt obliged to physically assault herself severely so that she could get her son charged with assault and jailed for protection and treatment.*

4. On 2nd September 2009 a family wrote to the hospital where their son had been admitted, to complain about the unsatisfactory leave arrangements on a number of occasions which at times had left him totally unprotected illustrating that the hospital did not follow protocol was not aware at all times of his whereabouts and could not inform the parents. Presumed he was with them and when in fact he was in the hospital and when he was supposed to be at the hospital he was with them. It has taken more than a month to get a response with advice that new procedures were being introduced to address the problem. Documentation sighted.

5. *In October 2007 man with a long history of mental illness and attempted suicide in his 30s was admitted to hospital. This man was given unaccompanied leave for one hour from the hospital at 5 p.m. and at 6:15 p.m. he was witnessed jumping to his death from a bridge about 3 miles from the hospital. He had previously visited the bridge, and he was affected by the fact that his close friend had suicided a week earlier. The hospital notified the police at 2100. The family was not informed until 0200. The comment to the family after regretting the clinical decision to override guidelines was, "he would have done it anyway". The family had to pay some $8,000 for legal representation at the inquest in October this year.* Documentation sighted.

Intermediate.

1. 2004-5. A K A young woman (30's) with a history of two previous suicide attempts. She was able to walk out of hospital and suicide. She had left a long letter setting out her intentions and found afterwards. The psychiatric registrar noted that her observation level should be increased and this did not happen. The system itself was poorly structured but in addition the open door policy meant that people were freely able to walk in and out of the hospital without being checked. The external sentinel review made a number of recommendations including that the "open door" policy should be changed. It also brought to light that there was no standardisation in observation levels across the hospitals in the Area and it was found that in respect of two hospitals the observation levels were the same but reversed. It took five months to implement the recommendations of the report. Obviously the flawed system was a large contributor to the failure to protect. Documentation sighted.

2. 2005-6. B T Woman 31, borderline personality diagnosis and MPD. History of family child sexual abuse, adolescent abuse and rape. Virtually discarded by the service as untreatable and continually poorly

treated. Many suicide attempts over the years. On a number of occasions and expediently had to be admitted to an out of Area hospital to receive proper attention. There were continuing "demarcation" ownership problems across Area boundaries which worked against the patient's interests. A review was finally conducted but it applied only to two months and did not include the most serious of the incidents where B T was failed by the service again and again with police involvement and significantly was rescued from having poured petrol on herself to self immolate. On two occasions it was necessary to intervene and contact the service from the United States. B T now lives in Queensland and is receiving the kind of attention that has seen substantial elimination of symptoms to the extent that she is now being admitted to University. Her story was the centerpiece of SPERANZA submissions to the Senate and Garling Inquiries under her real name. Documentation sighted.

Earlier times.

Case. A. 2001 Report from mother. * (All official documentation sighted.)**
Young male (19) four previous suicide attempts, admitted Emergency Department North Sydney, for surgery to wrists, "no beds" , 5 assessments "not suicidal", no proper follow-up, shot himself 5 days later. Mediation process with family and SPERANZA to resolve the issues and define protective measures in the interests of preventing similar failures in service.

Case. B. 2000 Report from mother. (All official documentation sighted.)
Young man history of illness. Immediate prior suicide attempt with a note. Admission to Manly Hospital at first refused. Suicide note and same day attempt in car treated as a joke. Later admitted after pleading. Contacted father from hospital to say intended to kill himself *"in the morning"*. Mother contacted hospital pleading for admission to son, relayed conversation with father. Admission refused, pleaded for constant observation. Messages not passed to changeover staff. No written pro forma suicide risk assessments recorded. No formal critical observation procedure. Found hanged in the hospital next morning.

Case. C. 1999 Report confirmed by Area Health.
Hospital nursing staff member Macquarie Hospital, suicide on the campus, not found for 36 hours.

Case. D. February 2002 Hearsay report from involved SPERANZA member. ***
Youth 16 suicide attempt, Emergency Department Manly, for surgery to wrists. Not admitted despite pleading, "no beds", hanged next day.

Case. E. 1995 - 1999 Reports in media.
Young woman, Karlin Monaghan absconded from Hornsby Hospital, died under train. Damages settled out of court $750,000, 1998. Mother and brother subsequently hanged themselves together March 1999.

Case. F. 2001 Report from mother.
Man in public psychiatric unit North Sydney. Psychotic, disturbed, deliberately released by opening the doors then police called to bring him back.

Case. G. 2000 Advice from police inspector directly involved.
Crisis Team North Sydney, visited to "schedule" a male with police as observers, *on arrival had been dead for four days.*

Case. H. 2000 Report from wife.
Adult male, absconded from hospital Central Sydney, Missenden Unit, psychotic episodes, jumped from Anzac Bridge. Suicide attempt day before and three page suicide note. Admitted only after pleading. Widow is an occupational therapist specialising in mental health, and coordinator of a long term residential drug and alcohol program for women and children, who has worked in psychiatric units.

Case. I. 2000 Report from mother. ***
Adult male discharged from hospital Western Sydney Penrith without advice to parent (carer) then suicide attempt, profoundly injured.

Case. J. 2000 Hearsay report from member passed from staff member involved. ***
Young woman in D&A clinic North Sydney, assessed at high risk by junior staff member who reported it. No action taken. Subsequently drowned that night. Junior staff member not interviewed in critical incident review process.

Case. K. 2001 Report from grandmother.
Adolescent male mugged at a railway station on the way home, waited at hospital Emergency Department Hornsby with his grandmother for two hours, complaining of pain in the head. Without receiving attention ran from the hospital and met his father outside when an argument ensued. He ran off and was found about two hours later hanged in a nearby building.

Case. L. 2000 Report from mother.
Adult male (30), absconded from hospital Central Sydney Missenden Unit, died under train.

Case. M. 2000 Report from mother. ***
Young woman witness to murder threatened by perpetrator, subsequent breakdown . Could not get admitted to hospital (Illawarra) until after SPERANZA intervention. After admission and improved treatment was transferred to another unit and a new MO without experience accepted OK and discharged without follow up and without consulting parents. Disappeared and was found on the beach some hours later by police search after an OD and readmitted.

Case. N. 2000 Personal report. ***
Young married woman mental illness history disappeared from home to Blue Mountains, threatened suicide by phone to husband. Police search brought her to hospital Western Sydney Penrith, not admitted, "no beds". SPERANZA intervention gained her admission to another Western Sydney hospital (Cumberland). On another occasion when suicidal admitted but discharged early to make way for someone "more sick". Formal complaint about poor treatment on this occasion deferred pending mediation outcome set up by SPERANZA.

Case. O. 2000 GP contact and report. ***
Young woman suicidal, father suicide previously, relationship breakdown, resigned from oppressive job. Refused admission to Blacktown Hospital when her "out of area" GP applied, "no beds". Contacted by GP. SPERANZA intervention gained immediate mental health team involvement and psychiatrist collaboration with GP.

Case. P. 1999 Personal acquaintance, known at SPERANZA meeting. ***
Male with schizophrenia, in distress hearing voices, walked into sea, admitted to Manly Hospital discharged next day, returned to hospital admission refused. Left within 20 minutes jumped from cliff within 3hrs.

Case. Q. 1999 Personal report from sibling.
Married woman in country town suffered from depression for 12 months. Could not get mental health service, no local service. Only contact with mental health was by phone from next town. Suicided at home.

Case R. 1995 Reported in Hornsby Advocate
A young woman Karlin Monaghan a professional model, walked out of Hornsby Hospital without leave and died under a train. To and a half years later in October 1998 the family received $750,000 out-of-court settlement. In December that year the father died from stress. In the March the following year the mother and brother hanged themselves together in their garage

What is SPERANZA?

Club SPERANZA has been operating true support groups for people actually at risk of suicide as well as for bereaved families for almost 20 years.

SPERANZA

- is a specialist suicide prevention and mental health advocate founded in 1994.
- the SPERANZA membership is a mix of people who have attempted suicide are bereaved and aggrieved by suicide, experience all kinds of mental illness or people or organizations who are sympathetic to SPERANZA's aims and objectives.
- Suicide support group operator. Pioneered and conducted hundreds of suicide support groups. All categories affected by suicide
- Advocates for families following a suicide particularly suicide in care.
- Participated in examination and review processes in Mental Health Services for 10 years.
- Mediator with grievances in the service.
- Conducted the first series of Tragedy of Suicide and Communities That Care public forums. Participated in many TV suicide documentaries and publications.
- Co-hosted world renowned psychologist Martin Seligman to Australia to promote learned optimism.
- First aboriginal healing sessions at La Perouse after three suicides in two months.
- Conducted specific national/international conference on suicide, "Moment of Choice".
- Annual Mental Health Festival Day at Manly. A major health promotion event to celebrate absolute social inclusion with all communities, bring together the disabilities visible and invisible, integrate with other services, promote mental health as the pre-eminent force in all human endeavour and address suicide prevention.
- Devised, trialed and tested Hold Out Your Hand suite of integrated programs.

Tony Humphrey Profile

- 50 years in business divided between engineering and life-insurance management to senior management level.
- 30 years in "mental health" in the management of mental health agencies including chairman and vice president Mental Health Association, past board member Mental Health Coordinating Council and ARAFMI.
- Taking part in/organising dozens of events, conferences, forums, seminars.
- Self funded study of best practice suicide prevention and mental health service delivery over a number of years across the USA and other places.
- Conducted hundreds of support groups and worked personally with hundreds of at risk people.
- 8 years in health promotion & education programs for senior adults.
- Founding three suicide prevention agencies; Australasian Association for Suicide Prevention (AASP) 1989, Suicide Prevention Australia 1991, Club SPERANZA 1994. Daughter Michelle suicide at age 23. Son Peter assisted suicide age 49 (terminal illness)
- 19 years member major committees in the Area Health Services including chairing Mental Health Community Consultative Committee NSCCAHS 8 years, 5 years Suicide Prevention Standing Committee and continuing member the Acute Care Committee NSCCAHS 1.3 million pop.
- Chairman SUNSR (Service Users North Shore-Ryde) Consumer/Carer representatives and Area management operations participation advisory committee.

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Open disclosure definitions and principles

Open disclosure is the free discussion of incidents that result in patient harm. The elements of open disclosure are an expression of regret, a factual explanation of what happened, the potential consequences and the steps being taken to manage the event and prevent any recurrence.

Principles for open disclosure

- Openness and timeliness of communication – When things go wrong, patients and their family and friends should be given as much information as practicable about what happened in an open and honest manner.
- Acknowledgment – All adverse events should be acknowledged to the patient and their support people as soon as possible. Healthcare organisations should acknowledge when an adverse event has occurred.
- Expression of regret – As early as possible, the patient and their support people should receive an expression of regret for any harm that resulted from an adverse event.
- Recognition of the reasonable expectations of patients and supporters – The patient may reasonably expect to be fully informed of the facts about an adverse event and its consequences, treated with empathy, respect and consideration and given appropriate support.
- Staff support – Healthcare organisations should create an environment in which all staff encouraged to recognise and report adverse events and are supported through the open disclosure process.
- Integrated risk management and systems improvement – Investigation of adverse events is to be conducted and should focus on improving systems of care.
- Good governance – Open disclosure requires clinical risk and quality improvement processes through governance frameworks. It involves a system of accountability through an organisation's Chief Executive or governing body to ensure changes are implemented and their effectiveness reviewed.
- Confidentiality – Policies and procedures should fully consider patients', carers' and staff's privacy and confidentiality, in compliance with relevant law, including Commonwealth and State/Territory privacy and health records legislation.

Effective risk assessment

Comprehensive Suicide Risk Assessment Guidelines

Engagement Protocol

The Basic Requirement.
The basic requirement should be a one-page protocol for easy referral in **first engagement situations** stated in the First Person so that even a neophyte or untrained person can follow …. *"This is what I have to do"*, and set out *" this is what I have actually done and when ……."*
Follow-on assessments can be much simpler.

Example:
This is what I have done:

- ❑ Engaged with and reassured the client. In my opinion I have established a genuine rapport with the client. OR. In my opinion I have not established a genuine rapport with the client and I have sought another colleague to attempt this.
  That colleague is; ……
- ❑ Completed a suicide risk assessment; my assessment is… Crisis x
  Crisis abated x
  Stabilised x
- ❑ Clinically assessed the client. (Assessment attached)
- ❑ Set up a protective environment for the client with a constant companion.
  That companion is ……..
- ❑ Ordered further assessments/investigations, medical, clinical, historical, spiritual, emotional, psychological.
- ❑ Met with the carer/s and informed them, and discussed the present needs and possible future needs, and their and our ability or inability to meet those needs.
- ❑ Created a CARE PLAN and advised those who are part of that care plan. OR.
  I have yet to advise them.
- ❑ Advised/shared with my next colleague my appreciation of the situation.
  That colleague is ……..
- ❑ Notified appropriate personnel/departments. OR.
  I have not yet notified those personnel or departments.
- ❑ Recorded my actions and the CARE PLAN and documented the clinical details.

Tick/Note the steps achieved,
and the DATE is; …… and the TIME now is; ……

Please advise any information which prevented these actions.
……
……
……
……

Signed ……

Clinician, therapist, nurse, social worker, OT, other. (circle)

Tony Humphrey 27th December 2002

TeenScreen® National Center for Mental Health Checkups at Columbia University

Key Facts about Mental Health Screening and the TeenScreen Program

Mental Health Screening for Youth is Effective

Screening is an accurate predictor of mental health problems that may develop into more serious conditions. In a study examining young adults several years after they had participated in TeenScreen in high school, two-thirds of those who made a later suicide attempt or went on to experience a major depression in young adulthood had been identified as being at risk in high school.[1]

Clinicians in school-based health centers (SBHCs) using screening tools to assess students who present for services correctly identify three times the number of depressed youth, five times the number of anxious youth, and four times the number of youth with multiple disorders as compared to SBHC clinicians who do not use screening tools.[2]

Rates of self-reported suicide attempts decrease when screening is combined with education about suicide and its prevention.[3]

The U.S. Surgeon General has highlighted screening as an effective method of youth suicide prevention.[4, 5]

The President's New Freedom Commission on Mental Health places a high priority on the implementation of voluntary school-based screening programs.[6]

TeenScreen is Effective

We know that TeenScreen is effective because it accurately identifies youth who are suffering from mental illness or are at risk of suicide, most of whom would not be identified otherwise.

Teens who are at risk for suicide at the time of the screening will be identified through the screening process.[7]

Teens identified through TeenScreen go through a two-stage screening process to determine which youth are truly at risk and need a complete evaluation. All youth who initially screen "positive" on the screening instrument are interviewed by an experienced mental health professional to make a determination about the need for additional services. This two-stage process ensures that only those youth who truly are at-risk get a referral beyond the screening for a complete evaluation.

Teens who are experiencing depression, anxiety, and drug or alcohol abuse at the time of the screening will be identified through the screening process.[7]

In a study examining the overlap between students identified by TeenScreen and those thought to be at risk by school administrative and clinical professionals, it was found that 40% of those with recent suicidal ideation or lifetime attempts were identified through the screening only, and were not known to school professionals.[8]

29% of those with a mood disorder, 36% of those with an anxiety disorder, and 16% of those with a substance use disorder were identified through the screening only, and were not known to school professionals.[8]

Screening accurately identifies 63% of students with a significant mental health problems, while school professionals accurately identify 37%.[8]

In the absence of screening, over one third of high-risk students would have been missed: 100% of the teens with suicidal ideation or a prior suicide attempt and a current mood, anxiety, or substance use disorder were identified by the screening, while only 63% of these teens were identified by school professionals.[8]

TeenScreen identifies 15 times the number of high school students in need of mental health services as compared to an in-school mental health program.[9]

Only 1.6% of suicidal teens who also meet criteria for a clinical diagnosis are already in treatment with a mental health professional.[10]

Suicidal ideation tends to be associated with decreased help-seeking behaviors in teens. One TeenScreen study showed that at-risk adolescents who do not request help on the screening questionnaire are significantly more likely to report recent suicidal ideation as compared to those who request help.[11]

Screening not only increases referrals but it also increases service utilization. Service utilization after TeenScreen was significantly greater in those who screened positive as compared to those who screened negative, both with regard to school services (34% vs. 4.1%), and community services (10.6% vs. 2%).[12]

The President's New Freedom Commission on Mental Health recognized TeenScreen as a model program in its July 2003 final report.[6]

TeenScreen is included in the National Registry of Evidence-based Programs and Practices (NREPP, a service of the U.S. Department of health and Human Services Substance Abuse and Mental Health Services Administration.[13]

Screening is Safe

Mental health screening and directly asking youth if they are thinking about suicide or have made a prior suicide attempt does not put the idea of committing suicide in their heads, increase suicidal ideation, or create distress.[14]

Teens who participated in screening did not have higher distress levels than teens who did not participate. This was true immediately after being screened and two days later

Screening participants did not have higher rates of depressive symptoms than non-participants

Screening participants were not more likely to report suicidal ideation after completing the screening

Depressed teens and previous suicide attempters who were screened were less distressed and suicidal than depressed teens and previous suicide attempters who were not screened

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The inner being of suicide.

SOLITARY CONFINEMENT

You laughed at my inadequacies;
so I dared not show them

You crushed my dreams;
so I dreamed alone

You were too busy to hear;
so why should I speak

You handled my confidences indiscreetly;
so I ceased to share them

You were insensitive to my needs;
so I smothered them

You never showed an effort to understand;
so I had no reason to communicate

Your indifference pained me;
so I hid my suffering

You wouldn't let me close to you;
so I kept my distance

You cared for my bodily needs;
so my spirit became destitute

You led me into myself;
so here now

I am imprisoned .....

anon

The Moment of Choice.

An attempt to gain that understanding of the moment and capture the ambivalence and the determination and the futility and the fatalism and the failure and the desire for release, surcease of pain, yet withall the vestige of hope until that last moment.

Moment of Choice.

The "moment of choice" the sage was calling it.
The moment; when lustred future vain and glory-filled or
ordinary-seeming simple, plain, yet compassed by some faith
in self or being far superior, the God above; is there ahead
for Him to bless...

The moment comes; when mind is strangled by a vine of
wretched hopelessness a growing parasite that coils and
twists and starves and sucks the vital juice of life or
life's desires, or life itself inherent ... beautified ... supreme ....

The moment comes: when former future now replaced by
future stark and real unpleasant sad or morbid cheerless even
everlasting failing ... hopeless; which then becomes
unfathomed turbid deep and black the utter pit.

The moment comes; the moment when the heroes fail ...
have given all ... can give no more;
the moment when it seems as though they're cast upon some fatal shore.
Ahead unknown and fraught with fright, sheer terror of the future filled...
Behind, a black lagoon with equal terror of the past ...
recalled in constant image in the mind, unable to be killed.

The moment;..... lives and thrives where seeming nought exists, not as we know ...
but some unseen insensible surreal electric flow continuum,
but yet it alternates and oscillates and vacillates withal till captured, caught ...
the only option peace, which can be sought or bought no other way
and seems the only valid thought.

This moment; when futility has marched against futurity
and found it wanting, lacking hope and courage future faith
in self or other being. The arguments for life are there, sure;
unread unheard unsaid ... or balanced 'gainst the need
for peace sublime ... escape the pain - the nameless fear,
escape the scream; the hideous fugue, the silent scream,
within the head, to purge it from the psyche clear.

No friend is there when moment nears, presage its future emptiness totality,
none is there to say let's think again
to find a better future glimmer faint, however pale or distant far, some promise yet ...
the Saviour's hope.

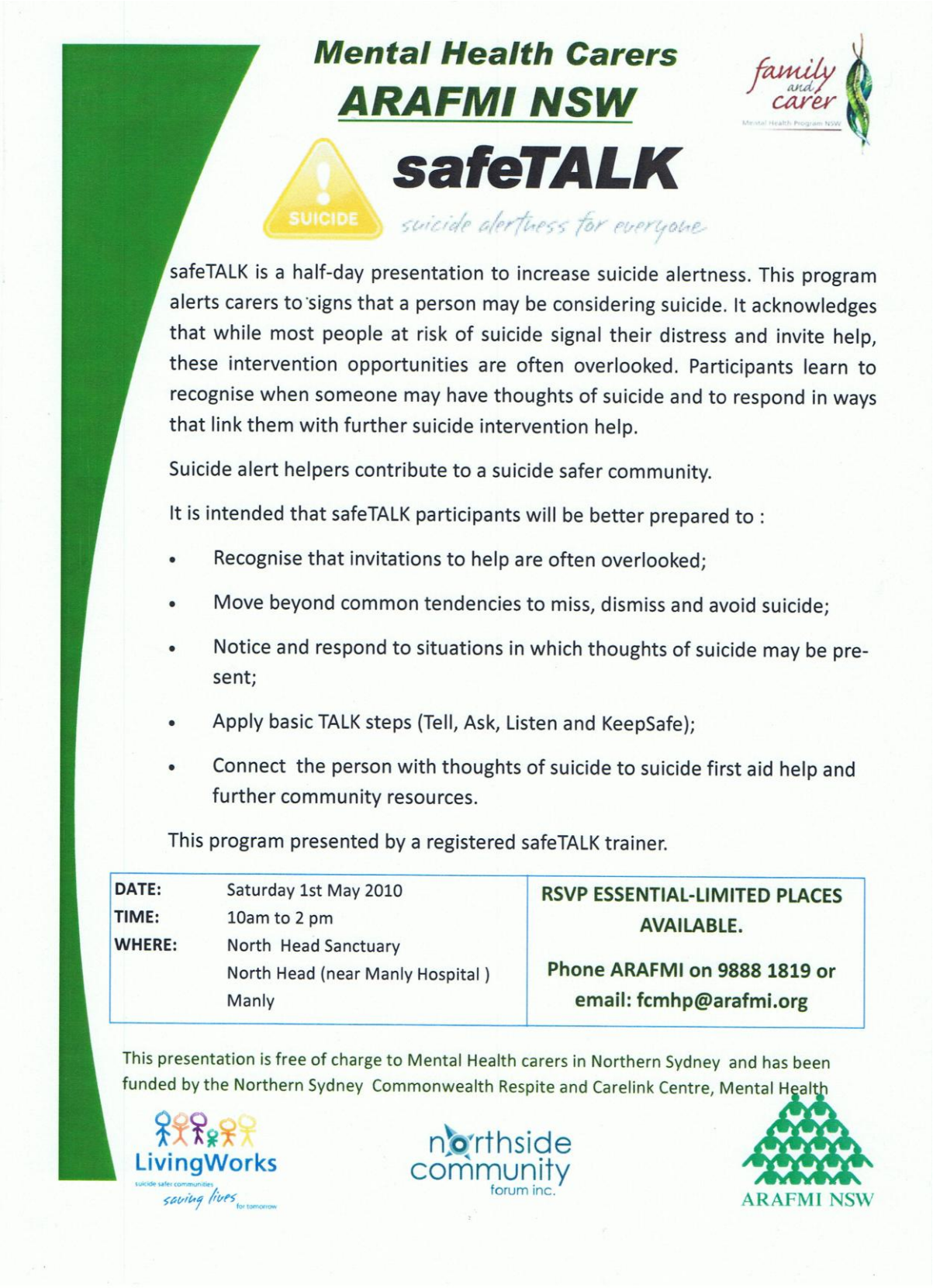
The moment comes; always alone, not by itself, but by
one'self, to steal the last the only evanescent self-assurance vestige left.
No sounds ... save those that plague the mind as purely thoughts,
as quarantined in silence absolute complete, no vision clear;
save bitter bleak and black and white of YES or NO.

The moment comes; demanding... yet its call so soft ...
insidious whispering pleading forcing guileing; do it, do it;
make a choice! To stay and fight another day?
What does it say?

The choice itself; is not the voice articulating "yes" or "no".
The voice is not the choice itself; deciding, which way should I go?

The choice is simply in the air, it's there;
ethereal ephemeral transient fleeting ...
a moment speeded slowed or paused in space and time-continuum.
Yet never caught as final lasting halted stilled abrupt.. the end ...
until that moment ... fixed .....
Until decision made, until the choice elected clear and ultimate,
the absolute, the consummate ..... finished

Characteristics of suicide SafeTALK



Mental Health Carers

ARAFMI NSW

family and carer

Mental Health Program NSW

SUICIDE

safeTALK

suicide alertness for everyone

safeTALK is a half-day presentation to increase suicide alertness. This program alerts carers to signs that a person may be considering suicide. It acknowledges that while most people at risk of suicide signal their distress and invite help, these intervention opportunities are often overlooked. Participants learn to recognise when someone may have thoughts of suicide and to respond in ways that link them with further suicide intervention help.

Suicide alert helpers contribute to a suicide safer community.

It is intended that safeTALK participants will be better prepared to :

- Recognise that invitations to help are often overlooked;
- Move beyond common tendencies to miss, dismiss and avoid suicide;
- Notice and respond to situations in which thoughts of suicide may be present;
- Apply basic TALK steps (Tell, Ask, Listen and KeepSafe);
- Connect the person with thoughts of suicide to suicide first aid help and further community resources.

This program presented by a registered safeTALK trainer.

DATE:	Saturday 1st May 2010	**RSVP ESSENTIAL-LIMITED PLACES AVAILABLE.**
TIME:	10am to 2 pm	**Phone ARAFMI on 9888 1819 or email: fcmhp@arafmi.org**
WHERE:	North Head Sanctuary North Head (near Manly Hospital) Manly	

This presentation is free of charge to Mental Health carers in Northern Sydney and has been funded by the Northern Sydney Commonwealth Respite and Carelink Centre, Mental Health

LivingWorks

suicide safer communities

saving lives for tomorrow

northside community forum inc.

ARAFMI NSW

Tony Humphrey
President
Club SPERANZA
PO Box 96
Neutral Bay NSW 2089

20 April 2010

The Australian Senate Inquiry into Suicide in Australia

This letter is in full support of the submission from Club SPERANZA on suicide and prevention in Australia.

The Disabled Surfers Association of Australia Inc. has for several years worked with and supported all Club Speranza's attempts to bring this issue to the attention of all authorities.

For the past 24 years we have directly dealt with people with every disability imaginable. For every person with a physical disability there is the possibility of some level of mental health issue.

Suicide is something we have experienced within our own organisation and are well aware of the factors that can trigger suicide. As a totally voluntary group, it should not come down to organizations like ourselves to manage and or deal with such threatening processes, yet we do.

The DSAA fully support every aspect of the Club Speranza submission to this inquiry.

Yours sincerely,
Gary Blaschke OAM
DSAA Founder and National President

PO Box A14 Enfield South NSW 2133 Mob. 0424 890 455 Office 02 9759 0997

Mental health is not illness! Summary.

Until we get leaders including politicians with sufficient status, marketing expertise, and business background propounding this argument, mental health and mental ill-health will continue to be subservient and the backseat passenger - we will continue to lose people from illness and avoidable adverse events i.e. suicide and suicide in care and tremendous injury from suicide attempts.

In NSW we used to have The Centre for Mental Health an iconic institution with an iconic head Professor Beverley Raphael ,,,, now we have the "mental health drug and alcohol office" a mixing and confusion of the engine of all human enterprise with the demon that causes illness and total devastation and is a treatment stream not an ideology ,,,,,

We can only get resources physical, material, financial and ideological applied to mental health if we have the right attitude from the top down beginning with the politicians, instead of expecting the sufferers to change their attitude and putting the responsibility on them to change their attitudes and be responsible for their own recovery - and when they kill themselves being blamed for having an illness ***"he would have done it anyway"*** (said to the parents after their son suicided an hour after being released on one hour unaccompanied leave and who had to pay out $8,000 for legal representation at the inquest to try and get explanations) - ***"there will always be those who will do it anyway"*** (Chief Psychiatrist of NSW Oct 15 2009 Suicide Prevention Forum) - ***"while it is known that not all suicides can be prevented"*** (objectionable platitudinous comment in correspondence from the Minister who has "no room in the diary" to meet),,,

Mental health is a leadership issue not only in presentation but in practice - without mental health there is no health - it is relegated out of the current health care reform propositions under discussion at the moment,,,,, we cannot excuse any failure to promote mental health as the prime mover in all human endeavour,,,,,

Mental health is the only "health" that specifically defines and identifies itself as an ideology not a disease - the only one that is a state of well-being - the only one that covers the entire spectrum of wellness. All other health categories for which we set up foundations for research and support are really illnesses and makers of ill health; cancer, diabetes, motor neurone disease, depression, cystic fibrosis, schizophrenia, melanoma, anxiety disorders, alcohol and drugs, Alzheimers the list goes on

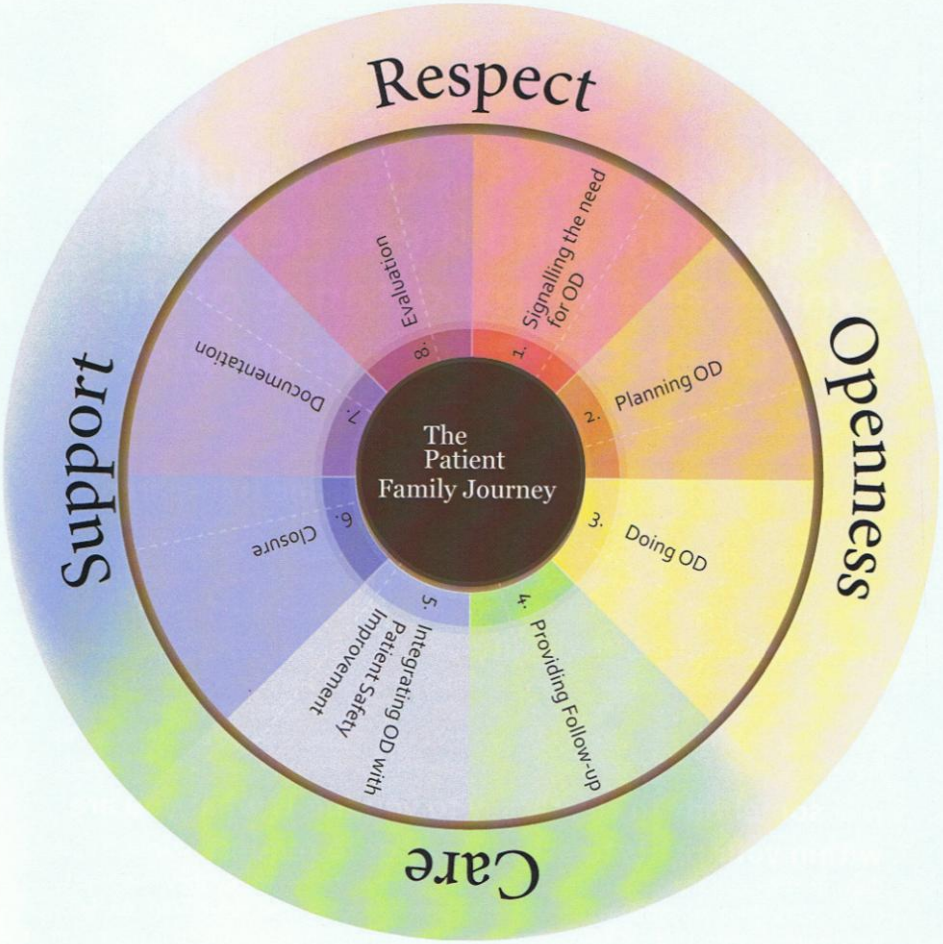
Until we have leaders who understand and promote the nature and the vitality of mental health against representations as health of its downside of mental illness or mental ill-health and making it merely a compartment in the box instead of being the box itself we will continue to be the voice crying in the wilderness ,,

The Open Disclosure Wheel

The basic principles of Open Disclosure.

(Reprinted from Open Disclosure Research and Indicator Development including the "100 patient stories project". UTS University of Technology Sydney, Centre for Health Communications)

The diagram below is the Open Disclosure Wheel. It sets out the Basic Principles and Indicator Domains:



In the next two sections of this document, we detail the following:

1. the Open Disclosure basic principles, respect, openness, care and support;
2. the individual draft indicators within each of the eight domains presented in the wheel: signalling the need for OD; planning OD; doing OD; providing follow-up; integrating OD with practice improvement; achieving closure; documenting OD, and evaluating OD.

The Power of Grieving.

"Sometimes grief and loss can become the passage price to fulfilment".

4th April 2005

Tony Humphrey

This paper was written to give some insight
into the characteristics shared by people at risk of suicide
and those who had experienced a suicide bereavement.
It explores the personal experiences on both sides of the suicide equation.
It is an aid to professional understanding of the need
for the service to relate to the person at risk

Part I. The Background.

The Wide World

On the 11th September 2001 "suicide" took on a new meaning for the entire world as the most potent weapon in international terrorism when the New York World Trade Centre and the Pentagon were attacked jointly by "suicide bombers", who were part of the al-Qaeda terrorist organisation. The horrified world condemned the perpetrators and grieved for those killed but only the fanatics grieved for those who suicided. The power of that collective grief swept the world and was a uniting influence. In a different context unique to Australia but partly as an outcome of the terrorist attack, "suicide" attempts took on another emphasis in relation to the asylum seekers held in camps within Australia, and brought forth a kind of collective grieving for the vanishing "Australian" way of life.

The Personal World.

In its world as a microcosm grief after a family suicide can hit like the bomb of the bomber. In the same way the world was changed forever after September 11th , when your child suicides your own life is changed forever. For a long time the power of the grief is only to punish and destroy. Huge brainspace-consuming questions emerge. But why? We struggle and writhe to find answers. This was my experience as a parent. Later after working with hundreds of people from both sides of the experience I came to understand vicariously the force and effect of the experience in other relationships. I gradually came to an understanding within of the power of directing my experience to reduce or at least try to temper the grief of others. I saw in many relationships where suicide can create separateness rather than unity.

The Day.

It had been raining heavily the night before but when the phone on the floor rang at about 8 o'clock it was a sunny Sydney winter morning. I had been making a cup of tea. The voice of my oldest daughter Anne came across, "We have been trying to find you." "Dad, Michelle has committed suicide". Suddenly what we had thought was a serious possibility (but wouldn't really happen because the mind wants to deny this unwelcome prospect), had happened. What had seemed not a probability but only a considered possibility and within the mind an unthinkable, was now a reality – even though from our experience it had been taken seriously and we thought it had been avoided. What had we done? Her mother had spoken with her a few days before and she was fine. I was calm and contained, yet I wasn't. I was matter of fact but I wasn't. I smashed the hand piece on the carpet (I was sitting on the floor). I asked straight questions I thought. I screamed or moaned, strangely I felt that was the thing to do even though I didn't feel like screaming or that I was screaming. My friend came from the other room thinking I was having a heart attack.

The Ordeal.

When Michelle our middle daughter of five children died in 1985 at the age of 23, and I had to identify her I wondered what I would see, how I would be affected? Would I break down? How would I cope? I had experienced death before, seen bodies before, damaged, broken, bleeding, unsightly, sallow, aged, wrinkled, distorted, contorted, unclean, wasted, young, peaceful or angry. I could only imagine the ghastly effects of carbon monoxide. In later years I was to see it in its worst form. I was lucky. I found a beautiful girl looking alive, healthy; clear skinned, eyes open, shining, hair shiny washed clean dark natural, living. There was a slight pink discolouration on her neck, like a slight rash. How could she be dead? Children don't die before their parents the mind tells you! Standing there numbed, what do you do? The viewing was through a window, surreal, almost clinical – not able to be touched or held. A young woman police constable handed me a green garbage bag with her clothes and personal possessions. I looked to see what was in her wallet. Was there anything to show what she had been thinking? What did she have with her in the last moments – a small amount of money, a signed drivers licence authorising organ donation and the usual cards etc.. Her clothes were clean but she had worn them. I explored them I sniffed them to sense her still living. They smelled faintly of her being. I cried. I cry every time when I read this.

Saying Farewell.

The funeral is manageable. Stiff-upper-lip time. The family suffers but the friends rally. After a few weeks of managing and being numbed we enter a time when (we now know that it is commonly around 12 weeks) the pain becomes enormous; the agony constant unescapable. It knocks out the psychological immune systems, it brings disorientation, paralysation of intentions and aims and everyday functioning; vacillation, procrastination. Misery and moodiness displaces happiness, guilt supersedes objective examination. Crying seems to happen every 15 minutes even without being visible. Fear, uncertainty, overcomes coping. Self-confidence vanishes, (perhaps never to be fully regained). There is a time dilation effect where the misery expands to fill all the vacant spaces in time. For years the grief comes in waves powerful, surging, overwhelming, relentless, but gradually the peaks and troughs even out and become further apart. In the early days it builds towards the anniversaries and Christmases and then relaxes to create further guilt that you should feel OK about yourself.

Michelle.

Michelle, quiet loving nature, warm hearted affectionate, had been an achiever at school; a Girl Guide patrol leader, good at sports and had a large circle of friends. She trained to be a primary school teacher and had a real yearning for that vocation but on graduation there was a glut of teachers. By the time opportunities presented she was well into a relationship over four years with a man seven years older. It was an imperfect fluctuating denying relationship, as so many can be, which she could not relinquish. He became diverted yet continuing so that that between each other they set up destructive interaction that resulted in two warning incidents. She believed that no other man would find her attractive and clung to her dream. At 23 after a five weeks separation (one of many), they saw a romantic movie together "Starman", with Beau Bridges, and reconciliation was discussed. A few days later after an unhappy confrontation, jarred by the presence of another girl with the man, and later angry phone calls, she left a note and drove her car to the edge of a lagoon, which had been a favourite parking spot. Just after midnight, with her eyes open looking peacefully out over the water she left this world.

From Young Life to New Life.

Michelle had signed her driver's licence for organ donation but that authorisation had no real effect in law at the time. In addition the effect of carbon monoxide and time had removed the possibility of most organ re-use. This was my given knowledge at the time. Some weeks later while reviewing the records with the police at the morgue, the sympathetic police sergeant made an observation to his constable that maybe it "might help Mr. Humphrey if he was given some information". He quietly advised that Michelle's heart valves had been removed (without consent, but that was not an issue with me). He offered the name of the professor for more information. I contacted the surgeon's secretary who told me in confidence that Michelle's heart valves had been transplanted into an 11-year-old boy whose life had been in danger. The police sergeant was right! It became an enormous comfort to know that such a vital part of Michelle was still alive and giving life to another.

Part II. The Journey.

The Why's and the Warnings.

We are continually knowledge-seeking, cramming, looking for understanding and answers, but never satisfied. One thing torments us why didn't we see it? We now know that the signs are there but usually we are not educated to see them and even if we are, sometimes we don't want to accept it or we are lulled by one of the most potent warnings, a warning which indicates that there is now nothing to worry about. The person is now OK and is happy and normal again and this is a welcome relief from the strain for those around the person. Vigilance relaxes. Even health professionals become caught out by this contra warning, perhaps even more so.

(I had called in to visit Michelle in her flat about ten days earlier because we were concerned about her state of mind. She was angry and upset with herself or him, and was angry with me for butting in (at that time I didn't know, but they had been separated for a month). She was constantly thinking about him and ran to the front door because she thought he was driving past. She agreed that we could talk the next week but not then. I believed after talking with her mother that she was now OK and I put off calling to see her to give her, I thought, a bit more time.)

Later we were to learn as well that for many experiencing the 'silent scream' over a long term, during a well period they can become so frightened to go back to the living pain, that they seek to end life while experiencing normality.

This type of experience can be one of the biggest creators of guilt and the "if only's".

The Fragility of Hope.

"All the great things are simple, and many can be expressed in a single word; freedom; justice; honour; duty; mercy; ***hope****."* (Winston S. Churchill. British war time prime minister)

The NSW Minister for Health the Hon. Craig Knowles, while opening a mental health conference in 2001 told a story and talked about people being exiled, and '*hope in Siberia*' *'for the future' 'hope for opportunity'.* Other speakers used it. Professor Beverley Raphael at the same conference followed the Minister and talked about '*capacity to mobilise hopefulness'*.

Hope can be fragile and ephemeral but still exist. Amid this disillusionment of grief and despair after a suicide our normality of hopes and dreams is put at risk.

When Michelle died my eldest daughter Anne said, *'Dad she didn't want to kill herself she hoped she would be found!' That's why it happened the way it did'.* I believe that she had told her lover that she would be in that favourite spot, and she **hoped** he would come for her.

Hope is that essential abiding human characteristic still remaining even when life is flickering out.

aliquam spem habere
(always have hope)
"The hope that leads us oft in dreams
to yearn, to wish, to tread it seems
on distant sand, or shore, or plateau high
or reach and stretch beyond our earthly tie
to fortune sad, or fate unkind; will
if we strive but hard enough, reward us still
with courage in our heart, to flourish and to fill
our latter days with triumph over all past ill"

Tony Humphrey 1993.

Grieving needs a purpose.

The grief experience can take courage. In my early stages I was at a convention and talking with the wife of the then Premier of NSW. They had lost a son. In sharing the experience I said it would take us a long time to get over it. She made the wonderful telling response, which epitomised the positive attitude and at the same time the needed comfort. It has always stuck in my mind. "*I don't intend to 'get over it', I intend to mourn him with love for the rest of my life".*

The power of grieving can help us to recover, to turn the disastrous negative to a positive; to find a new meaning or a new pathway where perhaps it may be the real reason why this pain has been given to us. Psychologist Dr. Tony Kidman the international specialist in depression and learned optimism, presenting in his Wellness Seminar in 1986 and recently in 2001 at a memorial service for Lifeforce in Sydney said to us the fact that you are able to say to yourself "I can't stand it any more" means that your brain is recognising it and you can stand it, otherwise you would not be here.

Around 1993, after exploring the emotions at first hand of other suicidal people I developed the expression "the silent scream" and wrote about the transference of that silent scream of the person suffering, to the family left behind. I wrote one of my early poems about overcoming the despair.

To There and Back.

(The Silent Scream)

When grief and pain the plaintive heart supines
with sadness over gladness it resigns
then failure and its partner gloom descended
oppress and crush the life not even ended.
Until the spark of nascent hope external
reflames the wetted soul eternal,
the joy of life renewed as once believed,
recalled from distant past when faint perceived;
and once again the utter darkness flees
from reborn human spirit that it sees.

Dedicated to those who suffer and suffered the "silent scream" Tony Humphrey 1993

The Power of Grieving.

Grief following suicide is like no other; from homicide, or accident or illness, probably because in most cases of suicide we are joined with the person in a relationship of continuation often genetic but certainly spiritually as hearts and souls, *and we feel that we had a responsibility which we neglected or failed to observe or because we should have been able to do more.* As well, in the circumstances of self-aided death we often cannot know for certain whether the person actually *intended* to die. In these circumstances the mind itself is subject to conflict. We can seek to blame others. We learned that one family can blame another whole family on the other side of a marriage. This blaming and hostility can be sometimes the only sustaining element of the grieving process. It is a power that sustains but a power which also damages and persists and wounds the innocent. It contributes to the perpetuation factor and ongoing suicide in families.

We can blame ourselves; we failed the person we have lost. This is not only a relationship with the person as in other losses but it is a relationship with the final outcome in which vicariously we played a part but from which we were excluded. It introduces to the grieving process other factors like guilt or inadequacy or anger or rejection or sense of failure, and which can then become an influence or desire to compensate or reverse the negative. There is a search for reinstatement of our own psyche, a need to return, to re-exist.

Part III New Hope, New Life..

Grieving Promotes Action.

The grief experience revolves around memories and the desire to never forget the person who was a part of our lives. We create physical and mental memorials. The memorialising process is a valuable part of the grief continuum. I carry not only a photograph but the words of the note she left, which are a picture of her mind, a window into her thinking. These are reconnecting tools. One of the questions we ask ourselves is, what was in their mind at the time?

Some continue to be held tightly by the personal memorialising bonds, others move to create a lasting memorial of challenge and renewal within the community. From there the power of grieving turns on a reactive-enzyme effect that wants to move mountains, to make change.

The New Consumer Movement.

The SPERANZA Beginning..

The grief experience stimulates a powerful concern to try and protect others from similar and lasting damage. From my personal background in mental health issues and management would it be possible to create something to help others avoid such tragedy? Perhaps this could be seen as a part of the guilt reaction and the need to compensate. To me it seemed a natural opportunity to bring experiences together for a better purpose.

There were three women among many whom I met during these years who had begun to move mountains and influence thinking about suicide and grief; Margaret Appleby, (Lifeline Director, author of publications about suicide & founder of Rose Education which brought together information about suicide and presented many awareness and training programs); Suzane Fabian school teacher researcher and author of "The Last Taboo" 1986 (who had attempted suicide herself was one of the first in Australia to raise the debate about youth suicide); and Petrea King. Petrea's loved brother had suicided in India and she having been trained as a nurse and later survived leukaemia, used her experience to change the lives of others and founded "Quest for Life". She began a career of turning around the living outlook of many thousands afflicted with life-threatening illnesses and consequent depressive pressures. I met Petrea, as she said "serendipitously", when we were both doing interviews at the same radio station. Remarkable for entirely different reasons, these women themselves showed that courage, persistence, determination, and love of others could work changes in self-harming or depressed lifestyles. Both Petrea ("Spirited Women" 1995) and Suzane ("Left-Wing Ladies" Sue Fabian & Morag Loh, 2000), have written books about the special qualities of some Australian women.

Around 1990, I had met Margaret Appleby and she organised a meeting in 1991 of people from several bodies: Sydney City Mission, Salvation Army and Lifeline getting together with others who had a background or relationship with the issue, and culminated in the formation of the Australasian Association for Suicide Prevention (AASP). After several meetings, I was voted executive vice president with Margaret Appleby as a member of the Management Committee. In 1993 AASP, merged with the newly created and funded National Youth Foundation to become Suicide Prevention Australia where I met Suzane Fabian and I remained its first "consumer" member of the National Committee until 1996.

Changing Direction.

All the conventional data being presented about "suicide" did not reflect the reality either in numbers or the crippling devastation and personal mental and physical debilitation, which follows and leads to suicide perpetuation. For me the learning process we all experience began to include an understanding of the proportion of suicides who were affected by a mental illness. For many it was not an event that came "out of the blue" although our mind in torture would like to influence us to believe that it was.

The word "suicide" itself is often inaccurately applied, is brutal and hostile to the suffering mind (the shocked grieving parent so often says, *"it wasn't suicide! My son/daughter wouldn't do that!";* it is not necessarily descriptive and thereby exclusive of so many family situations.

In the early nineties there was no real suicide prevention, intervention and after support service and mental health services were becoming increasingly inadequate and even distant. Also I was a person who listened a lot to others and tended to accept and respect and defer to the views of "experts" or people who seemed to have all the 'real' knowledge. As a parent who had experienced what I felt was the major effect of suicide over some nine years, fourteen years experience in mental health too, and had embarked on setting up support groups for people depressed and grieving, it was a shock that others involved in "suicide prevention" could so easily discount my experience pyramided on the experience of others who shared the enormous heartache. One of the most senior academics in public health in Australia when I offered an opinion said, *"you don't know anything about suicide!" "What do you mean I don't know anything about suicide?" "Well you've never written a paper and had it published!"* We have learned that attitudes play a big part in dealing with the issue.

From 1994 I felt there was an undue emphasis on academic research and education (noble though this was) and began to realise the distinction and lack of real representation in supportive terms between those who were experiencing the grief from loss, and the grief which comes from being occasionally, or frequently, or sporadically, or consistently suicidal. I realised that these people are the real "survivors".

At this time the mental health consumer movement was beginning to emerge and to stake its place. I began to think about creating a "consumer" body to be the advocate and representative of this large unique affected group of individuals and families.

A New Partner.

Carol Jefferson is a Registered Nurse with psychiatric nursing experience, a graduate in nursing education from the University of Minnesota and mother of Cole who had lived the experience of suicide over years instead of months or days. Together we recognised that there was no such specific "consumer" and advocacy organisation representing families with personal experience of suicide and self-harm history. It could be a body that would advocate for all concerned about the issue, even though the idea of this being a group of deserving "consumers" was hard to get across. It would be a natural concomitant of the growing ethos of community and consumer caring, and concern about the after effects of suicide. We set about the beginning of Club SPERANZA and Carol supplied the faith to keep the enterprise going.

The Renewal of Hope.

Hopelessness can be an abiding characteristic so it was felt that a one-word symbol was needed to promote the aims and the theme of recovery. The Association for Mental Health Suicide Consumer Advisory Group, which eventually became the Australian Mental Health Suicide Consumer Alliance or Club SPERANZA (meaning "hope" in Italian) was created. SPERANZA also stands for "Suicide Prevention Education Research Australia & New Zealand Action."

Grieving and the New Ethos of Prevention

The original intention was to provide a support mechanism specifically for families etc. who had become bereaved by suicide. We shared the experiences of every kind of suicide relationship and the horrors of the damaged, the dismembered, the disfigured, and the memories that this evoked. We shared the experience of several suicides in the one family and the sense of inevitability and resignation. Always I felt lucky.

In due time it became evident by the involvement of others across the board that there was a strong preventive element evolving. This came from the inclusion of people who had made previous attempts or were experiencing mental health problems and others who, individually, fitted all the categories.

With time we begin to appreciate the emotions and the mind workings of those who attempt suicide and we begin to recognise that they are the real survivors because they have been there! The term "survivor" was being misapplied. By using it to describe the bereaved we were demeaning and invalidating the existence of the people who were still here after the attempt/s and thus creating a divide in understanding; a separatism that was harmful to both sides. We could see that there was no specific organisation available to them, which could validate the person who was self-harming and at risk of suicide. We wanted to create an opportunity to allow them to feel that there was a hope for a future and recovery instead of a state of ongoing existence.

We learned from them about the feelings of those caught in the self-harming lifestyle; of their very often damaged early lives. We learned from them where prevention could have most effect. We learned from them that they could suffer every day; that they were frightened of dying "scared to death"; but worse to go on living! Notes left put it, *"I'm scared of dying but I'm more scared of living (in torment).*

We learned that strangely the hopes and dreams of both sides were not greatly different; that each had experienced great loss or never found anything worthwhile to lose. One young survivor (who had a brutal upbringing) listening to the grieving bereaved said, *"I grieve too, I grieve for my own suicide."* Another, with two suicides in the family and an abused early life said, *"I wish I could feel that emotion for others that they have for me". "Maybe I will be able to find it."*

From the survivor side we learned what those at risk needed, to be able to renew. From the carers we learned of the long term anguish when illness and self-harm is entrenched. From the bereaved we learned how to share the grief without taking sides. We learned from the families that the power of grieving can be applied constructively helping to turn people around.

We learned that suicide is frightening; that most people really don't want to be involved with people who are self-harming and threatening. In turn this further isolates the person at risk. In the Australian society it is a fact of human nature applying equally to many clinicians. Before the event it is difficult to deal with the person in this mode of self-destruction and after the event difficult to deal with yourself.

"When"

Uneasy are they who suicide dream
Tortured are those who suicide scheme
Hopeless and lost it fills their scene
Hopeful must we who would intervene

Tony Humphrey 1994.

A Paradigm Shift.

Experience informs action; personal individual experience stimulates personal action, personal broad-spectrum experience contributes to constructive positive interactive new generation purpose. We gradually began to believe that even in the most emotionally damaged or disordered or illness state, if sufficient resources and time is available that it is possible to reconstruct the damaged lives and return them to the enjoyment of life rather than the preoccupation with or resignation to despair and self- destruction.

My own association on clinical, consultation, planning, and service committees and the creation of consumer and carer projects brought insight into the problems of management in the service environment and the difficulties of achieving a common aim. We learned that different kinds of education of the community and of the health services are needed. We learned of the differences between the bureaucratic vision and the non-government agency vision. The bureaucracy is bound by policy that may be constrained by resources or driven by a monarchical concept that can be indifferent or selective. Policy can be stated and unstated and differently interpreted according to the vision of the individual and how that individual sees her/his place in achieving the vision.

The essential difference is that the incorporated NGO is a legal entity and exists to represent the needs of its members or constituents.

Suicide the Unsimple.

Suicide is not simple, as we are constantly told. While "suicide" deaths are often compared with deaths on our roads, with time comes a realisation that no official records or death statistics coronial or ABS give a realistic or accurate picture of the size and ramifications of the problem, or its distinctiveness and relevance to Australia itself. Even worse, being only an indicator at best they can misdirect thinking to the outcome and encourage further misdirected research for academic answers instead of action. The most powerful indicator of where energy should be applied to the greatest effect is the measure of suicides of mental health clients against the total. In NSW, this has risen from around 10% in 1995 (Centre for Mental Health. Public Health Bulletin Vol. 6 No. 8 August 1995 J. Chipps et al), to a suspected 30% - 40% in NSW in 2000-2001. ("*In this* ***context*** [follow-up of clients]*,* ***self injury and suicide must be monitored in mental health clients to ensure the NSW Health Department is discharging its responsibility to provide protection from serious physical harm".*** Quote PBH Bulletin 1995***)***.

Thus the mental illness perspective and lack of effective services for people at risk after identification began to dominate the intervention component as observed by SPERANZA. It is not much good identifying people without the services to treat them! The existing paradigm of "suicide prevention" needed a rethink. It meant a considerable broadening of awareness of the increasing impact of drugs and consequent mental illness as well as the social contributors to desperation. It led to a rethink in terminology that could be relevant across the spectrum; the appropriateness of the term "survivor" is one example; "self-aided death" is the sad experience of many who will never be able to determine whether their person actually intended to die or not. The outcome is the same because of the path taken by the person leading to the end; hence the expression "self-aided death" and its acronym SAD. We began to use this to more typically represent suicide but encompass all those which were indeterminate or denied or suspect and with just the same anguish this kind of death evokes. It acknowledges that it is a *sad* event and also means, "stay away from drugs".

The Rewards. Returning from Grief.

In time grieving can become an energy force rather than a debilitating force. When that happens the reward of experiencing change and motivation emerging in the individual encourages a vision for the wider community. We found with the families left in the wake of suicide or SAD a tremendous passion to help, to serve. But the haunting devastating effects can cripple the capacity. As well it is natural to put aside association with the subject and to try to move on to avoid the return of the disempowering emotions. Rewards come from gaining an understanding of the different motivations of the "prevention" protagonists. Different rewards again come from being connected to

other agencies that make referrals, from being posted on the Internet and being contacted from overseas by Email or phone to be asked to intercede with a person in distress locally. The rewards come from changing the culture of apathy and ignorance and the poor attitudes to those who are suicidal or with mental health problems that can lead to suicide. Mental ill health is not something that the well part of community wants to recognise *…."Suicide is something that won't happen to me, I could never do that". "Suicide is the ultimate selfish act". "Suicides are traitors and cowards". "A mother would never kill herself and leave her children". "If people want to stick a needle in their arm let them do it!" "You've talked about killing yourself all the time why don't you go ahead and do it"!* A parent at a seminar said to me around 1993, *"I can't take it any more I'll be glad when he does it!"* We talked. It gave me the opportunity to be able to tell him, *"no you won't.*

Where to? The SPERANZA Centre.

Ever since its formation SPERANZA has had a vision of a place of its own from which it could provide its own phone-in call centre for those in distress to have quick access to professional services and a range of therapeutic and support options including meeting with like-minded and like experienced people. At the end of 2001 "The Year of the Volunteer" SPERANZA took a bold step and combined into premises next to its new modern office.

The Power of Grieving Multiplies and Empowers Others.

People like Petrea King, Liz Mullinar AM, ASCA (Advocates for Survivors of Child Abuse), Ron Barr (Youth Insearch), Tony Trimingham (Family Drug Support), Ken Marslew AM (Enough is Enough), Margaret Appleby AM (Rose Education), Chris Riley (Youth Off the Streets) and others, were all motivated to create something powerful driven from a background of grieving from their own experience, or grieving for others or from the experiences of others.

The New Life.

The experience over the years has been extremely testing of personal emotional resources for the promoters as well as the damaged. However SPERANZA's vision of a new integrated service and the new Centre together offers a continuum of hope inspiration and courage from togetherness, sharing, and support.

Within this philosophy we can begin to delight in a new life, a renewal which applies equally to those at risk and those who grieve.

Ode to Joy

When morning comes I lay awake not quite.
Seduced still by dragging footsteps of the night,
reluctant still to see invading light.
Not yet prepared to live to move.
Not yet the constant sadness shed.
The past repeating circuiting thoughts within my head
seem huge and daunting frightful prospect still of damaging the day ahead
but yet there glimmers some bright rays,
some golden shaft it now appears and flits from wall to floor
and with its soft appealing vision warms the joy within and dormant
till the heart quiet moved excited feels its glow and swells and murmurs
this is new today ... this is you today .... *this is you as new today*

Tony Humphrey. 1997

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Select Committee Inquiry into Mental Health in NSW

In 2001 – 2002 on the instigation of Dr. Arthur Chesterfield-Evans MLC, the NSW Parliament established a Select Committee Inquiry into Mental Health in NSW, chaired by Dr. Brian Pezzutti MLC. The hearings of this committee were dominated by suicide issues and particularly the traumatic open hearing which became the foundation for the ABC Four Corners program "Duty of Care". This program together with extraordinary personal stories presented a SPERANZA meeting of a large group of families affected by suicide, which had been created to establish a specialist dialogue with the mental health services.

ABC Four Corners was awarded the Human Rights Commission Television Award for the year for clearly setting out the failure of the mental health services in practicing its duty of care.

Since then the Sentinel Review Committee has been established to examine suicides of mental health clients and published its first report "Tracking Tragedy". The report clearly shows that it is more by good luck than good management that there were not more suicides during the period reviewed.

A further review of suicide post discharge from hospital brought out the comment that most resulted from lack of follow-up services.

The Power of Grieving in Rebuilding.

SPERANZA came about because of grieving and the need for peace and recovery. Because of grieving Margaret McKay was donated a million dollars so that a health farm retreat based on the Swedish model to save young people from drug addiction and SAD (self aided death) could come into being. Petrea King and her "Quest for Life Foundation" retreat "Killarney" came into being because of grieving. Liz Mullinar created "Mayumarri" for those who have been damaged by sexual abuse. Tony and Angela Wood addressing the drugs problem with young people. Tony Trimingham developing "Family Drug Support". Things like these can happen because of the positive power of grieving.

To look beyond today.

In New Zealand South Island at Otago near Dunedin at a place called Aramoana there is a memorial plaque commemorating the shooting massacre of 13 people in 1990.

"If it is for your comfort
to pour your darkness into space,
it is also for your delight
to pour forth the dawning of your heart."
"The Prophet" Kahlil Gibran.

Grieving is a part of life. We learn by it. We gain a power from grieving. It makes our life significant even though painful. The grieving process is honest, it is searching, it does not spare us in its attempts to understand the why's. But like faith it can give a meaning to life. However our society and faith bring us up with an underlying inherent denial. It should not happen. *Even if we knew that it could happen we don't want to believe it!* Death should not happen other than by "natural" causes or terminal illness, or by accident, which then gives a compensatory comfort of reason or justification, or faith (God's will) or by the other death, homicide where there is anger at the perpetrator.

Well meaning friends and counsellors can talk of "letting go" - "knowing when to let go"! This is a very subjective decision but as well as that it needs to be understood from both sides; the person who has left and the persons left behind. Nan Witcomb captures the explanation and importance of this personal judgment.

"One day,
it will be time
for you to leave -
I only hope
I love you enough
to let you go ..... "
Nan Witcomb "The Thoughts of Nanushka"

pam driscoll
[redacted]

23rd April 2010

To: The Australian Senate Inquiry into Suicide in Australia

As a result of childhood emotional and sexual abuse I have a long history of anxiety and depression. I have also been diagnosed with and received counselling for post traumatic stress disorder. Some years ago I came very close to suicide.

I am a member of and a volunteer for Club SPERANZA. For years Tony Humphrey has tried to obtain better outcomes for people suffering from mental illness and to reduce the incidence of suicide. He and Club SPERANZA have supported them, their carers and their families. In particular Club SPERANZA offers help to those left behind after a suicide of their loved one. These people are themselves at risk of suicide and there is nowhere else for them to go.

I wholeheartedly support the submission from Club SPERANZA into Suicide in Australia. For far too long the mentally ill and deeply distressed have been given insufficient care and virtually no hope. We are not detritus. We are humans who, in our hour of suffering, need to be treated in just the same way that physically ill humans are treated - with dignity and given every chance of recovery. No medical professional should ever assume that a life is not worth fighting for. But when it comes to the mentally ill, they do not fight. The figures on suicide need to change if we are to live in a world with hope.

I commend Club SPERANZA for addressing the failings of the service, the inability of practitioners to relate to and deal with consumers and their families and for detailing so well the poignant stories of those the system has failed.

I sincerely hope that the Senate Inquiry will make a difference and improve the lot of those at risk of suicide. Too many people die, people who would have lived if only the service had been better attuned to their needs. I trust the Club SPERANZA submission will help you in your deliberations.

Sincerely

[redacted]

Pam Driscoll

cc Jeff Kennett, Beyond Blue

Pam