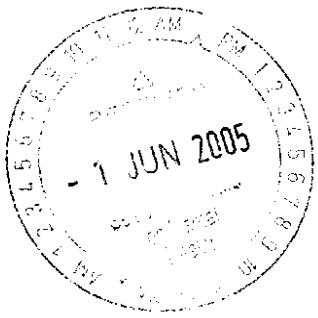

Senate Select Committee on Mental Health

Submission [redacted]

April 2005

We believe that we are able to contribute in an informed way to this enquiry, based upon our experiences in caring for our daughter. She was diagnosed first with Bipolar Disorder and then Schizophrenia in July 2001 and late 2002 respectively. In November 2002 she made two attempts at suicide, and after the second was committed to a Mental Health Unit (MHU) at a Sydney hospital. After a further suicide attempt while under care there, she absconded some three months later and finally committed suicide in February 2003.

We identified numerous failings in the treatment and care provided to her at the MHU by the responsible Area Mental Health Service (AMHS). These were the subject of a Coronial Enquiry into her death, held in May and August 2004. We are still pursuing several issues arising:

- our complaints about failures in the treatment that she received from some of the nurses and psychiatrists at the MHU is currently under review by the NSW Health Care Complaints Commission

- we have also made complaints about several of the MHU and AMHS administrators to the Chief Executive of the AMHS, as a result of which he is carrying out an External Investigation into what he regards as our serious allegations

- through our State MP, we are endeavouring to find out from the NSW Minister for Health, what actions he has taken in response to the Coroner's Recommendations made at our daughter's inquest

Our submission below, then, is based upon our very extensive experiences of various aspects of the current situation with regard to treatment of mentally ill persons in NSW. It identifies what we consider are some generic problems that we believe the Senate Select Committee will wish to consider in its Enquiry and makes recommendations to deal with these. It is arranged to address the published Terms of Reference for the Enquiry.

Terms of Reference (a) and (c)

Recommendation 1. Re-balance the proportion of the health budget spent on mental health

It is clear that a root cause of many of the problems with the system for treatment of mentally-ill patients can be attributed to poor funding, both in absolute and relative senses. For example, mental illness accounts for 27% of all disability, yet only 7% of the public health budget is spent on it.

We are confident that other submissions will deal more knowledgeably with this central issue than we can.

Recommendation 2. Ensure that *action* is taken by Federal and State Governments, not yet more fact finding or talk

There have been numerous recent enquiries into various aspects of the care of mentally ill patients. For example, see:

Carers of People with Mental Illness Project (Mental Health Council of Australia). Final Report, June 2000

Mental Health Services in NSW (Select Committee on Mental Health, NSW Government). Final Report, December 2002

Tracking Tragedy Report of NSW Mental Health Sentinel Events Review Committee, December 2003

Review of the Mental Health Act 1990; 1, Carers and Information Sharing (NSW Health, NSW Government). February 2004 and in progress

Review of Mental Health Services in Australia for 2003 – 2008 (Mental Health Council of Australia), 2004.

Tracking Tragedy Second Report of the NSW Mental Health Sentinel Events Review Committee, March 2005

Review of the Mental Health Act 1990; 2, Operation of the Mental Health Act (NSW Health, NSW Government). July 2004 and in progress

We strongly believe that the facts concerning the faults in the current system are well-known and it is time for **ACTION** by State and Federal governments.

In this regard, we were pleased to discover recently (December 2004) that the NSW Government plans to implement 51 of the 52 recommendations of the excellent document ***Tracking Tragedy***. However, it is unlikely that this alone will be sufficient to redress the parlous state of mental health care in NSW. Furthermore, given past history of **failure to implement** (see sections 10 and 11 below), such implementation must be audited by an independent body.

Related initiatives need to take place in the other States, since mental health care is a State responsibility. Indeed, the importance of a Federal enquiry such as this is that it has the opportunity to bring about necessary changes throughout Australia.

Term of Reference (b)

Recommendation 3. Ensure that Area Health Services review the expertise and qualifications of Crisis Team members and protocols for their guidance

In the case of our daughter, a Crisis Team from the MHU visited her at our home two days after her first suicide attempt. Our daughter said she thought the visit was useless and she could not understand the team's role. They did not give us any information on how to look after a suicidal person (as they should have done according to "Community Management of Suicide Risk", AMHS June 2001) and in fact they hardly communicated with us at the time. Our impression was that they were either too inexperienced or lacking in training to make useful assessments and/or to take the necessary action. Our daughter took an overdose of her antipsychotic medication only four days later in her second suicide attempt. This tragic outcome led to an Area Mental Health Service Sentinel Event enquiry as to why more hadn't been done.

In the case of another patient, a Crisis Team from the same MHU failed to come to her home as promised, or even to contact the family. A visit from the Crisis Team was to be part of her management plan. The girl's mother also received no guidance on how to manage someone who is suicidal and her daughter committed suicide on 8 June 2000, 12 days after the crisis team should have visited.

We believe and recommend that Crisis Teams should preferably include more senior and better-trained members and/or that otherwise they **must** refer the suicidal person to a hospital psychiatrist for review. This should be the case even when, as for our daughter, a private psychiatrist is involved, to get a second opinion. They should also follow the written procedures and provide information to the Carers on how to look after the potentially suicidal person.

Term of Reference (e)

Recommendation 4. Redress the current too-low level of supported accommodation by increased spending in this area

When our daughter's psychiatrist at the MHU decided that she should be discharged (prematurely in our view and perhaps because of the pressure on beds), she was adamant that she did not want to live with us, her parents, as in her eyes this would mean a loss of independence and somehow signal regression or defeat. Unfortunately, at the time, there was no suitable supported community accommodation. We believe that this was one of the several factors that drove her to commit suicide and was part of her conviction that she could not put her life back together.

The Richmond Report of 1982 recommended decreased institutionalisation of mentally ill persons and increased community care. This has led to a decrease in beds available in hospitals, but Federal and State governments have failed to provide the necessary community care resources to balance this. The patient is thus now much worse off. This situation needs to be redressed urgently.

Terms of Reference (g) and (k)

Recommendation 5. Ensure that Area Health Services improve information provided to Carers, and overcome privacy constraints

We would have been much better equipped to help our daughter if we had received more input from the MHU and had more discussion with the treating psychiatrists. A part of the information that we needed but did not have, was a better insight into the disease itself, its salient characteristics and likely progression and into the medications and other treatments used and their likely outcomes and limitations. Indeed, one of the Coroner's Recommendations at our daughter's inquest concerned provision of information to Carers (see ***Attachment 1***, *Coroner's Recommendations, Item 4*). Provision of such information should be entirely non-controversial since it does not involve patient confidentiality issues.

On the patient confidentiality issue, we have a very clear view. We would rather have our daughter alive with some of her rights having been set aside than dead with her rights (uselessly) preserved intact. Mentally ill patients are mentally ill, and need to be protected from themselves, as in any case their admission to a mental health unit implies. In our view, the NSW Mental Health Act's caution on this issue of restriction of liberty, though well meaning, is misguided and gives the wrong guidance. The most important "right" that a mentally ill person (or an outside person coming into contact with a violent patient) has is the right to life, and all other considerations should be subservient to this.

Our suggestion is that a single primary Carer should be identified at the time that the patient is scheduled, and simultaneously given legal status by the scheduling magistrate. In most cases it will be obvious who this person should be, and the magistrate should be given discretionary powers for any cases where there is contention. Under these arrangements, there is no need to exclude anyone from this role in the Mental Health Act, and it automatically ensures that the carer is 'legitimate'.

For more extensive comment on this point, please see ***Attachment 2*** (our *Submission to Review of the NSW Mental Health Act; Discussion Paper 1: Carers and Information Sharing)*

Recommendation 6. Ensure that State Departments of Health provide a counselling system for bereaved relatives/carers after a suicide and inquest, within the coronial system

The Coroners Courts in Glebe and Westmead in Sydney provide a free Grief Counselling Service for relatives and carers of persons dying "sudden and unexpected deaths", as part of the Department of Forensic Medicine. This Service is supported on an *ad hoc* basis by one or more of the Sydney Area Health Services. We have found the service provided at Glebe to be exceptionally valuable and supportive over the past two years since our daughter's suicide. We therefore recommend that a similar service is attached to all

Coroners Courts, and that financial support for this service is centralised and included as an essential component of the Department of Health budget.

Term of Reference (l)

Recommendation 7. Take action to reduce stigmatisation of mentally ill persons

Our view of mental illness is that it is an insidious form of illness no different from other physiologically based or inherited illnesses. Schizophrenia struck our daughter down, depriving her of her ability to deal with or to enjoy life, and ultimately led to her suicide. Mental illness is harder to cure than, say, diabetes or cancer, and equally distressing in its progression.

However, we realise that many others do not hold such an informed viewpoint, and we strongly support increased efforts to educate the Australian public, probably best through the mass media, in order to reduce inappropriate and distressing stigmatisation of mentally ill persons.

Terms of Reference (m) and (o)

Recommendation 8. Make external review within the State Departments of Health into deaths under care mandatory and establish pre-determined protocols for these to follow

We were "fortunate" that the failures in the treatment that our daughter received in the MHU and in the protocols and procedures there were so obvious that an External Review was arranged within the AMHS. However, this was the first such enquiry held, despite numerous previous suicides by patients being treated there. The holding of such an enquiry after a patient death should be made **mandatory**.

Furthermore, it became clear to both us and the Coroner during the inquest for our daughter, that there were faults both in the Committee membership and in the extent of the investigation. Key questions had not been asked of key staff members, and we ourselves were not involved, merely informed after the event.

As a consequence, one of the Coroner's Recommendations concerned this issue:

> "IT IS SUGGESTED THAT IF THE SYSTEM OF EXTERNAL REVIEWS IS TO BE MAINTAINED PROTOCOLS SHOULD BE ISSUED TO ENSURE THAT THE REVIEW IS THOROUGH, INDEPENDENT AND ITS FINDINGS AND/OR RECOMMENDATIONS BE DISSEMINATED THROUGH MENTAL HEALTH SERVICES - AREA HEALTH SERVICES STATE-WIDE."

(see ***Attachment 1,*** *Coroner's Recommendations, Item 5*)

Recommendation 9. Require that State Departments of Health hold clinicians and administrators more accountable for their actions, and require their counselling and mandatory re-training where their failures have contributed to death

An extensive series of faults in the Health Service that contributed to our daughter's absconding from the LMU and ultimate suicide, were uncovered by our own efforts, by the External Review carried out by the Health Service, and by the Coronial Investigation (see ***Attachment 1,*** *Coroner's Recommendations, for a limited summary*). The persons responsible for these failures included nurses, psychiatrists and administrators.

In summary,

- psychiatrists failed in the treatment provided to our daughter and in not following correct procedures, particularly in documentation and communication, while nurses failed in their administrative roles and in recognising obvious discrepancies in patient symptoms and treatment

- administrators failed to ensure that adequate operating systems were in place and to audit such systems that were in place to ensure that they were being correctly followed by clinical staff

These same persons, so far as we are aware, currently continue to work in the same positions without having been held properly accountable for their failings and without having received the benefit of re-training or counselling. Thus we are concerned that without serious attempts to recognise and correct such failings, they will continue to recur.

We believe that when such failings have been identified as contributing to a death in care, re-training of those persons responsible should be made mandatory.

Recommendation 10. Introduce measures to ensure that Area Mental Health Services audit the implementation of Critical Incident Review recommendations and report in writing on these to the Department of Health

After our daughter's death, we became aware that numerous recommendations had already been made to the AMHS in response to several previous suicides. These were made by internal Critical Incident Reviews, Sentinel Event Reviews and, where inquests were held, by the Coroner.

To our dismay, we realised that had these recommendations been implemented, particularly those concerning inadequate risk assessment, documentation and communication by psychiatrists, our daughter's life may well have been saved.

We are unable to establish whether, in the case of Coroner's recommendations, the fault was in failure by the Minister for Health to order the changes recommended by the

Coroner (see next section) or in failure by the Area Health Service to implement adequately changes ordered by the Minister.

We reviewed some cases relevant to this issue in the document "Prior Recommendations to NSAMHS" (see ***Attachment 3***).

Recommendation 11. Introduce measures to make a response by the State Minister for Health to Coroner's Recommendations mandatory

We are currently attempting to discover what action the NSW Minister for Health has taken regarding the Coroner's Recommendations arising from our daughter's inquest, made on 18 August 2004. We are doing this through our State MP. The delay in response to our enquiry (some 2 months so far), even though the Coroner's Recommendations were made eight months ago, plus what we have read about the poor communication between Coroners and Ministers for Health in such cases, makes us fear that the Minister's response will be less than what is required.

We believe and recommend that it should be mandated that a written response from the Minister of Health is provided to the Coroner and copied to the Carer in cases such as ours where death of a patient under the care of the Health Service has occurred. Otherwise improvements to the Service arising from the pertinent comments of the Coroner may not occur – allowing such deaths to continue and depreciating the (extensive and expensive) efforts of the Coroner.

As in the previous section, the Department of Health must audit the implementation of the Coroner's and the Minister's recommendations. Regrettably, experience shows that it cannot be simply assumed that this is done by the Area Mental Health Services.