Bringing about "SPERANZA"

"The first Australian suicide consumer-alliance."

Club SPERANZA

Established 1994.

SUBMISSION TO

SENATE SELECT COMMITTEE ON MENTAL HEALTH

AUSTRALIAN SENATE

MAY 2005

This submission attempts to address some of the issues in the national mental health scenario drawing to a large extent on practice in NSW, the Parliamentary Select Committee Inquiry in NSW 2002, and the "Tracking Tragedy" reviews. Implementation is slow moving and there is very little evidence of improvement in therapeutic practices and interventions on the ground.

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2. **Recommendation.**
   Ensure standardisation, consistency, and uniformity in acute units in providing, comfort, support, understanding, compassionate response and treatment.
3. **Recommendation.**
   Implement the recommendations of the NSW Mental Health Sentinel Events Review Committee, "Tracking Tragedy" Reports 1 and 2 across jurisdictions.

Suicides. A Reflection of the Adequacy of Mental Health Services.

4. **Recommendation.**
   Revive and implement the National Mental Health Strategy and Plan.
5. **Recommendation.**
   Instal the Northern Sydney client suicide data collection model across jurisdictions as a yardstick and working tool for assessing the effectiveness of service delivery and recognition of the deaths of known people and not just de-identified dehumanised statistics.

National Mental Health Administration and Funding.

6. **Recommendation.**
   That a Mental Health Commission or similarly constituted body and as described in the paper **"Australia needs a mental health commission"** Rosen A. et al be created.
7. **Recommendation.**
   To ensure the delivery of effective mental health services in future planning and some parity with the mental illness population demographic; that funding allocated for mental health across jurisdictions be programmed to automatically increase on an incremental basis over five years to at least 16% of the collective health budget in keeping with international trends.
8. **Recommendation.**
   Pilot programs that achieve their objectives be assured of ongoing funding while being subject to ongoing monitoring processes.

The Relevance of Suicide Data in Mental Health.

9. **Recommendation.**
   Adopt the proposed new definitions and standardise the client suicide data across jurisdictions to aid realistic planning and discovery of systemic problems.

Addressing Stigma

10. Recommendation.

- The inclusion of families, carers, and significant others in the legal framework of intervention, support, rehabilitation and recovery.
- Carers to be given appropriate status and formal recognition under legislation to enable them to take an effective role in the management of their adult family member.
- Institute a program to ensure that therapists/health workers are effectively trained in how to build relationships.
- Mental health advocacy and participation courses for consumers and carers and positions as paid advocates are valuable services.

Duty of Care

11. Recommendation.
   After a suicide in care under the Open Disclosure practice, the service immediately express regret and condolences in writing and provide the financial, medical, psychological, and social welfare support etc. as above.

12. Recommendation.
   Seclusion is an appropriate and necessary adjunct in the acute ward but needs to be utilised appropriately with discretion and not as a power or punishment mechanism.

13. Recommendation.
   Establish time-out and respite arrangements for mental health nursing staff in hospitals to allow for comforting interaction with patients and ensure that standards are set to ensure that patients are not subjected to reductive language.

Recommendations cont.

The Building Blocks of Community Service. Building NGO Capacity

14. Recommendation.

- Introduce a small grants subsidy scheme for voluntary NGO's.
- Initial subsidies on a one-off basis up to $10,000.
- Provide start up funding, growth money; ongoing low level recurrent income support to build infrastructure.
- Establish a funding pool to allocate infrastructure support for agencies able to demonstrate the effective and consistent operation of support groups especially for those at risk of suicide or bereaved by suicide.

15. Recommendation.

- To certify the equal place of NGO's in the health funding hierarchy and properly develop community based care; to elevate incrementally over five years the proportion of mental health funds allocated to NGO community based care from 2-3% to 20% of the mental health budget.
- Establish centralised specific NGO finance departments to assess NGO funding needs and process applications until actual funds transfer to the organisation.

Workplace and Community Education & Training.

16. Recommendation.

Introduce a national uniform LivingWorks Applied Suicide Intervention Skills Training and train-the-trainer program.

17. Recommendation.

Carers, families, formal carers networks and consumer networks are important and integral support mechanisms. Carers and consumers must have equal status and consideration in the preparation and operation of the client management plans.

18. Recommendation.

Carers must be allowed greater financial support and access to benefits.

Suicide Risk Assessment. Admission, Discharge and Community Management.

19. Recommendation.

Replace "high" "medium" and "low" descriptors with "crisis" "crisis abated" "stabilised" "no foreseeable risk". Until by consensus clinical review the person is "stabilised", observation in safety conditions must be continued until there is no foreseeable risk.

20. Recommendation.

Ensure that the recommendations of "Tracking Tragedy" 2 or similar in relation to community follow up are implemented across jurisdictions.

Community Mental Health; the New Vision.

21. Recommendation.

Ensure that Mental Health Area Directors or their equivalent in other jurisdictions have equal status with other Directors at Level 2.

22. Recommendation.

Appoint Area Health Service Mental Health Compliance Managers across jurisdictions.

Supplementary Section Recommendations.

Reviewing Mental Health Services in the Community

1. Recommendation.

The government to conduct a research study of models of community service delivery including metropolitan, urban, regional and rural models across jurisdictions to assess best practice in the different settings and recommend most effective methods of operation and make up of service teams, taking into account the problems of topography, population density, rural distances, avenues of access and rapid response, communication, transport and the nature of material, human, and funding resources needed to support the desired models.

2. Recommendation.

For the purpose of linking community services and integrating the philosophy of community mental health services on the ground with the service personnel, government to establish and fund a body and a forum mechanism to facilitate the interaction of the extended hours and community teams and their relationship with each other and the acute services.

Preface to the Submission.

"Without mental health there is no health".

Population Health and the Health Equation.

There is a tendency to see mental health as an adjunct to the health system, and in the community at large and indeed in the health services there are contrary perceptions about "mental health". These contrary perceptions are aided by the frequent interchangeable use of the expressions mental health and mental illness; "mental health" is used to express mental illness.

On one side the weight and proportion of generic health considerations (disease states, resource and service demands) that concede a whole range of morbidity causes which can contribute to mental illness or mental disorder individually. On the other hand, there is the massive significance of mental health as an individual phenomenon in population terms i.e. 1:4 or 1:5 (added to by the huge numbers of their attendant carers and increasing the population affected proportion to around 30% - 40%), which when not effectively serviced/treated can exacerbate or initiate physical disorder.

This can be best illustrated by an equation:

Population Community Health = the sum of generic/physical health and mental health.

TOR (a) (c) (d) (f) (l) (p)

Mental Health Administration: Failure and Competition.

One of the big failures in mental health but exemplified in NSW was the ad hoc and crisis management administration of mental health. The central body the Centre for Mental Health, failed to see the deterioration in capacity and service that had occurred and was continuing, and to project and plan future needs with the certainty of funding to meet the projected increase in demand. This is largely due to the subservience of Mental Health to the medical model and in relation to what is seen politically as the broader demand of physical disease and disability burden.

These issues translate across all jurisdictions so that to achieve totally effective mental health service delivery there must be an acceptance at all levels of the concept of health as a balance between mental health and generic health services and not a competition between a majority and a minority in the system.

Australian Mental Health Suicide Consumer - Alliance Inc.

Officers

President Tony Humphrey
Vice President Janet Meagher AM
Vice President Glenys Jackson
Secretary Carol Jefferson BSc NE

Submission Sponsor

1. Speranza is the Italian word for hope and SPERANZA stands for “suicide prevention education research Australia & New Zealand action”.

2. The Australian Mental Health Suicide Consumer-Alliance Inc. (Club SPERANZA) is a specialist mental health advocacy and support organisation representing the interests of people at risk of suicide and self-aided death and their families, and those bereaved by suicide and self-aided death (SAD). Without government funding it has occupied a unique place in mental health promotion, advocacy, support, suicide prevention and intervention, education and training since its establishment in 1994. In this capacity it has worked with hundreds of people at risk and families bereaved by suicide and conducted over 250 inclusive support groups with combinations of those criteria. It has taken part in many television and other media appearances articles and journals and instigated many public meetings, forums and seminars. Membership is about equally consumers and carers and is individual, family, and organisational.

3. The organisation and its members played a significant part with its Open Disclosure Advisory & Support Group presented in the ABC 4 Corners program Duty of Care which portrayed substantial elements of the Inquiry and won the Human Rights Commission TV Award in 2002 for its exposure of the failures in the NSW mental health system.

4. SPERANZA was the instigator of the seminal study to compare client suicides against the total in the state of NSW (Centre for Mental Health. Public Health Bulletin Vol. 6 No. 8 August 1995 J. Chipps et al), now accepted as a yardstick. In NSW, this proportion of suicides against the state total has risen from 10% in 1995, to almost 24% year end 2000 (CMH Mental Health Quality Portfolio Feb. 2002 and ABS #3303 Causes of Death Australia 2000 by state) and a suspected 30% plus in NSW in 2001 and has been around 35% plus, at least in some Areas. (Central Coast Suicide Prevention Network Annual Report.)

5. The submission draws on lengthy experience as a delegate to national bodies and many national conferences over the years but much experience is derived from association with organisations and Area Health Services in NSW, principally the Mental Health Association, and the Mental Health Coordinating Council; in Northern Sydney, the Area Health Service in a long association over 15 years as a member of strategic planning committees and workshops, Suicide Prevention Standing Committee, Mental Health Community Consultative Committee, and including a review of mental health services undertaken by the Area Health Service referred to by its short name; the Curtis Report and the Colleen Wilson Health Strategies Northern Sydney/Central Coast.MH Services Planning Project and Clinical Services Reference Groups.

6. Club SPERANZA as a suicide prevention exponent has instigated a resilience-building program for young people with its own website called GASS “Go And Surf Social” with prominent surfers support including Layne Beachley as patron. It has conducted a number of surf days and other functions. SPERANZA also has its own on-call band for functions i.e. “Black & Blues” or the “GASS Band”.

7. Tony Humphrey is the father of Michelle who suicided in 1985 at the age of 23. He is a vice president of the Mental Health Association NSW Inc. and in that capacity has had input to the submission from that body.

8. SPERANZA has been a principal in public action and advocacy to retain and enhance community mental health services and recently in coordinating community action to prevent the closure of the Lower North Shore & Royal North Shore Hospital community mental health centres and the downgrading of the operating services.

A Consumer's Insight

A particularly insightful instrument is the letter (attached) from Tarian Kiana (T.K.) describing her issues and interactions with mental health services and police. Her statements have been echoed many times in our association with clients of the service their carers and families and are completely representative of the frequently entirely inappropriate attitudes to patient care or where the diagnosis or presentation is pre-emptively considered difficult or impossible to treat. e.g. Borderline Personalty Disorder, PTSD. OCD

The System.
"At the end of a day any system mental or otherwise can have an ideology, guidelines, practices that are supposed to be in the best interests of themselves, clients and society but the service will only ever be as good as those who implement them and those that are on the front line. If present/past or even potential clients are scared and/or angry at the way they have been treated by the Mental Health System how can it be positive for them or their family and friends." T.K.

On attitude.
I feel the behaviour and conduct displayed in these instances to be unprofessional and detrimental to myself. I have talked to many psych patients and I am not alone. The system is supposedly set up to help people with mental health issues but I guess people like me fall outside what they want to deal with. I hope that the attitudes and conduct of the doctors and staff within the system that are on the front line can be changed as they are doing more harm than good. T.K.

My Reactions.
With my PTSD I don't like the feeling of not being worthy of treatment and understanding as I would be if I was a war veteran. Or being told if you are going to do it do it don't call Lifeline. Or that you are only just sad. The depths of despair, hopelessness, sadness, fear, anger, depression. These are real to me. T.K.

Biography.
Tarian is a person who has been sexually abused by her stepgrandfather a war veteran (who died) and neighbours. Her earliest recollection being from the age of 2 to age 9, which raises unpleasant associations on ANZAC Day anniversaries in particular. She suffers from PTSD and frequent flashbacks from this abuse and being raped on another occasion. At the age of 16 she was witness to a murder where the victim was beaten to death. The case took 4 years to be finalised in court. She became a State Ward and lived in youth refuges. Tarian has a mental health services case manager and lives in community housing. She has had many hospital admissions over the years and is presently on a disability benefit while studying 2 days per week at TAFE with a year to go in her course.

Of hospitalisation.
"It's one thing to have your freedom taken away or restricted because you are deemed to be mentally ill disordered or a danger to yourself or others but once we are in these psychiatric facilities we should not be treated as second class citizens. Taking the time to spend 20 minutes sometimes shorter/longer to listen to a patient goes a long way. You can feed them medication, lock them away but that does not necessarily solve the problem." T.K.

Hospitalisation.
The following day I was seen by a male doctor who approached me in a common area and started to discuss my issues. I felt that this was inappropriate. He asked me did I feel I needed to be in hospital, to which I replied that I thought I did, as I felt unsafe within myself and scared. Before I could say anything else he said (words to the effect) how dare I put it on the hospital to make me feel safe and that there was nothing they could do for me and that I was beyond help. I started to cry and said you don't care do you? He looked at me with what I interpreted as a look of indifference and I said f##k this I am leaving. He said that he wouldn't stop me and that was that. I left crying uncontrollably feeling as though no one cared and that I was a waste of space. It was after this occasion that I decided that I would never go to hospital voluntarily again. T.K.

In hospital.
As in this particular open ward you could not go to bed in certain hours I laid on the couch. I was dressed in summer clothing and as the afternoon wore on I was feeling cold. When a nurse passed the loungeroom I asked for a blanket and she replied (words to the effect) its not a bloody bedroom and walked off. At the time there were no activities on and several patients lay asleep on the floor. It seemed they were left alone for a while and then when it appealed to the nurse she would nudge some of the patients and with a raised voice say they couldn't sleep there. I ask you what were they meant to do? T.K.

Suicide: The Silent Partner in Mental Health.

TOR (c) *Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care.*

Suicide: The Silent Partner in Mental Health.

An Overview of the Problems.
The consequences of community treatment preferences as predicated in the Richmond Inquiry are not matching the changing social structure. This means that many people with a severe mental illness or at risk of suicide or self-harm instead of being looked after in asylum environments, either in hospital or community settings, with modern treatment and rehabilitation methods and recovery training as an inhouse or direct complement, are forced to exist through lack of means and personal support mechanisms in an increasingly hostile environment.

The Silent Partner.
The silent partner of individual, service, and community mental health is suicide. To create, improve, enhance mental health and buy out that destructive partner we must have vision, and employ that vision to empower populations and construct and reinstate healthy environments by building infrastructure supports as well as services. We achieve best outcomes by changing attitudes and building the spirit of community enterprise and localised community supports and community services.

"Suicide" as a masthead banner is exclusive of individuals and families who don't fit the criterion (suicide defined by proof of intent) and don't want to recognise it. The Orthodox Churches deny it and refuse funeral services (unless the person was proven to have a mental illness). Families and carers who live with it fear it. It keeps lawyers and courts tied up in non-interpretations acceptable to some and unacceptable to others. In some religions it is a sin but that doesn't prevent it.

The Premise of This Submission.
Suicide is the sharp end image of mental health service delivery. Suicide can be dramatically minimised provided the people can be identified and receive appropriate therapy. Successful suicide intervention depends on identifying the persons at risk. For those outside the service, in the current climate without large scale community education and training programs ("suicide is everyone's business") most frequently the only time a person becomes identified is when they present to a health and particularly a mental health service.

Recently publicised and high profile suicides and the increasing proportion of client suicides clearly indicates the lack of effective treatments and understanding of the mechanisms necessary to address the problem <u>for those already in the system</u>. Suicide of known clients has risen to become a major proportion of all suicides and makes for a powerful representation of the failures of mental health services.

The Suicide Prevention Axiom.
The fundamental premise of this submission therefore is <u>a virtual axiom that the most effective way to reduce the incidence of suicide as a first event and the perpetuation or follow-on of suicide in families, is to provide better mental health/illness services</u>. Services must be supplemented with more appropriate caring services and a full range of low cost treatment options including the early intervention and prevention models and aftercare. These treatment options need to be supported by appropriate training in delivery.

Community Mental Health Services and Suicide.

Community Mental Health. A History.
In the late eighties community mental health services where established saw themselves according to their charter as set up to work with the "seriously mentally ill" and maintain them outside hospital. Rehabilitation and recovery concepts were few and far between but with ground-breaking methods under the leadership of Ms. Wendy Weir PSM were becoming embedded on the Lower North Shore and called "Living Skills".

The whole service created earlier by Dr. John Hoult and enhanced by Dr. Alan Rosen was predicated on keeping people out of hospital, reducing readmission rates and duration of admission. The service would later be acknowledged as leading the way in community mental health and receive national and international acclaim. Hoult moved to the UK to initiate similar concepts. This service over eight years lost 10 staff positions and came under threat of destruction by closure of two community centres and relocation to the Royal North Shore Hospital campus during 2004. There has been substantial community outrage involving four councils and consumer/carer groups and NGO's, and the proposal is currently under review.

1991 Review of Mental Health Serices.
In 1990/91 the first state-wide survey authored by Kevin Berry and Peter Gianfrancesco located at Ryde, was conducted into the operations of mental health teams. They were surprised to learn that some 60 - 70% of their work was with suicidal people and responding to suicide crises. They began to develop appropriate techniques. In addition they established the Extended Hours (crisis) Teams Forum, a body made up of the community teams which sent delegates to regular bi monthly meetings dispersed around the state to confer and compare and redesign on-the-ground operating methods and conditions. The forum also conducted some annual conferences. Club SPERANZA was privileged to be accepted as the only NGO non service member for 6 years until it was disbanded when workload pressures increased substantially in the late nineties and delegates could not get releases to attend.

Failing the Consumer and the Carers.
It has been said many times that we now discharge people with a health status which ten – twelve years ago would have been the criterion for admission. Many times we hear from people at risk who have been told *"we need the beds (your bed) for someone who is worse"!* Many times the suicide prevention community awareness training professionals outside the public system say, "*how can we say to people we are training 'when someone is suicidal get them professional help' and the help is not there or they get sent home". The police say, "we take them to hospital after a suicide attempt and they are sent home with no follow-up".* Carers in these circumstances say that they have to become "*the untrained unqualified de facto health professionals".* One carer says, after several suicide attempts and 1-2 day admissions, *"Mr. Humphrey, how long will I have to keep doing this for my son without treatment?"* (Extract from Parliamentary Inquiry submission 2002)

The Loss of Community.
In the eighties it was said that the system was set up to negotiate people into it, now it is set up to negotiate them out of it. However the community supports for effective therapy, rehabilitation and recovery are not being provided to the extent predicated under the National Mental Health Strategy and Plan and in conformity with National Standards. "Tracking Tragedy" illustrates the deficiency in follow up and community support leading to suicide and makes appropriate recommendations.

Community Mental Health Centres.
Those that do exist have in many cases been reduced or threatened. For example the closure of Glebe mental health facility in Sydney and others, the breaking up of Bridgeway House rehabilitation centre at Parramatta, and the attempts to close Cremorne and Chatswood Mental Health Centres. All this to shrink an internationally recognised best practice model of community psychiatric services and relocate and centralise them onto a major hospital site.

Lack of Consistency and Uniformity.
Even in these enlightened times the psychiatric service industry is an industry totally fragmented and without uniformity. Psychiatric hospitals and services are not universally and uniformly bad but neither are they universally and uniformly good. The valuable Curtis Report (ibid) highlighted the lack of uniformity and consistency in an Area Health Service, but its findings are comparable with other areas. In Northern Sydney until October 2004 there was little standardisation of practice across the hospitals which led to confusion in staff authorities and contributed to preventable deaths; for example observation levels in acute wards were structured differently and in two hospitals with levels 1-5 they were reversed. One had an "open door" policy with high numbers of absconders and absconding suicides, while others were strict in relation to ingress and egress.

At the level of primary policy decision-making there is no uniformity of agreement in the philosophy of involuntary admission and thence a tendency to justify avenues for the patient to abscond or absent as a better practice.

Tarian Kiana in her letter (attached) demonstrates the variation in treatment of patients and the attitude of staff. Whilst this is the experience of one person it is a sample confirmed many times over by consumers, especially those who are admitted for self-harm or suicide attempts.

Of Caritas Inpatient Unit.
Even though we had some disagreements he was a doctor that treated me with respect and dignity. In fact everyone at that hospital did. I have heard the speeches of staff shortages and funding shortages but I don't think there was a day I felt as though they thought I was beyond help or a joke. T.K.

1. Recommendation.
Ensure retention and expansion of the service-in-the-community ethos nationally through policy direction and funding.

2. Recommendation.
Ensure standardisation, consistency, and uniformity in acute units in providing, comfort, support, understanding, compassionate response and treatment.

3. Recommendation.
Implement the recommendations of the NSW Mental Health Sentinel Events Review Committee, "Tracking Tragedy" Reports 1 and 2 across jurisdictions.

Suicides.
A Reflection of the Adequacy of Mental Health Services.

TOR (k) *The practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion.*

TOR (c) *Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care.*

Suicides. A Reflection of the Adequacy of Mental Health Services.

Political Will in Suicide Prevention.

Suicide prevention has become a catch cry of the political scene and mental health bureaucrats over the years since dedicated involved people began to call for action in the late 80's. In reality the term should be "suicide minimisation". In 1993 the Commonwealth started to take a more serious interest in the relevance of suicide and set up the "Here for Life" youth suicide prevention project and strategy and began tendering to fund demonstration projects.

The attempted suicide of a Tasmanian senator and his courageous re-entry to public life and the suicide of another federal politician after party political persecution has perhaps given some emphasis to the government's interest in mental health issues.

There is a considerable time lag between policy and execution and the Mental Health Strategy and Plan has fallen behind substantially due to lack of will, lack of resources, lack of capacity.

The Two Dimensions to Suicide.

In the context of this submission there are two dimensions to suicide:
(a) **The personal.** Suicide is the everpresent prospect and the ultimate adverse event with the individual with mental health problems or diagnosed mental illness and the people close to that person.

(b) **The indicator.** Suicide, self-aided death (SAD) and deliberate self-harm is the primary indicator of the inability of the mental health services to handle the load, because;

- research tells us that over the years 90% -94% of suicides have been shown to have a diagnosable mental illness of which depression is the most prevalent;
- there is a world-wide trend of increasing depression only now beginning to be recognised in NSW with the creation of the Black Dog Institute, but in other states by the development of "Beyond Blue";
- of the increasing proportion of suicides in NSW of mental health clients that suicide (from 10% in 1995 to 24% in 2000 Mental Health Quality Portfolio February 2002) and now suspected to be 35 % plus;
- the substantial increase in dual diagnosis and substance abuse cases and forensic cases.
- the increase in the homeless population with a mental illness.
- the increasing reports of suicides following discharge or non admission to hospital.
- suicides in droughtstricken rural areas.

Suicide; the community health status indicator.

The increasing incidence of suicide, self-aided death (SAD) and deliberate self-harm overall is an indicator of the mental health status of regions and communities; e.g. large scale company layoffs, rural settings in drought conditions, and unemployment.

Suicide in discrete communities is an indicator of the state of mental health in that community and of the lack of adequate services especially over long distances.

Distance Difficulties.

Suicide minimisation most frequently depends on the capacity to negotiate with the person at risk and provide support and is an extremely personal interaction not usually amenable to electronic communication. Suicide is a crisis. It requires a "flying squad" approach person to person in negotiation, and training in negotiating techniques.

Suicide of Clients, the Effectiveness Assessment Tool.
The proportion of suicides and relative numbers among people who are known clients of the health service or who have been identified at risk and been admitted to the ambit of the service by contact and assessment, is the most powerful measure of the ability or inability of the health services to deal with the syndrome of self-destructive self-harming suicidal behaviour in order to deliver an effective mental health service. Suicide of known mental health clients has become the ultimate performance indicator of a mental health service.

4. Recommendation.
Revive and implement the National Mental Health Strategy and Plan.

5. Recommendation.
Install the Northern Sydney client suicide data collection model across jurisdictions as a yardstick and working tool for assessing the effectiveness of service delivery and recognition of the deaths of known people and not just de-identified dehumanised statistics.

National Mental Health Administration and Funding.

TOR (a) *The extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress.*

TOR (c) *Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care.*

TOR (o) *The adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards.*

National Mental Health Administration and Funding.

Mental Health. Quantifying the problem and the resource requirements.
On a population basis mental health/illness collectively makes up the largest proportion of disease/disorder i.e. around 20% of the population and together with its attendant and indispensable carers grows to a proportion affected of around 35% to 40% of the population yet receives only 6-7% of the health budget compared with around 12-14% in other developed countries and up to 24% in some. Included in this mental health population is the nominal 35% of women and 15% of boys who are sexually abused as children from early ages to adolescence with a mean age of 9-10 and those as well who are physically and emotionally abused which almost inevitably leads to self-harm and making up the suicide numbers among mental health clients in later life.

In order to address the problems and ensure effective continuing service delivery nationally and on a long term basis two essential elements are required.
(a) An advisory mechanism to oversee the planning, implementation, and service delivery on an ongoing basis.
(b) The assurance and certainty of adequate funding as the strategy and planning processes develop and projects are undertaken and not merely subject to annual ad hoc pleading.

(a) The Strategy and the Mechanism.
It is well known that the National Mental Health Strategy is falling behind. Implementation of the Second Mental Health Plan is in arrears. *"SANE Australia's Mental Health Report 2002 – 2003 concluded that Australian mental health services are in disarray and operating in crisis mode and that the National Mental Health Strategy is widely recognised to be losing momentum and faltering".*

The Barrier.
A major and costly barrier to effective integration of services and service delivery across the country and the implementation of recommendations and strategic plans e.g. National Mental Health Strategy and NMH Plan, is the fragmentation, dissimilarity, disunity, non-coordination of services and policy response, lack of consistency, of commonality, and an appropriate mechanism able to federally accommodate/coordinate the forces of action, the stakeholders issues, the advocacy for and the flow of funding, and implementation of recommendations under the national strategy (and those arising from this Senate inquiry), across the states.

Curtis Report.
"All these worthy things can be done --but not within the current configuration of services and the resources available for mental health services in New South Wales. It is simply not viable to expand the service expectations without significant investments of resources: money for additional staff and staff development in new competency areas, new program initiatives and service approaches, and so forth. The "enhancement" funds given to the Areas are helpful, but are not at all sufficient to meet the local need or the expectations of CMH." **(Centre for Mental Health)**

A Federal Body.
Since 1995 this organisation has been arguing for a federal mental health commissioner supported by commissioners in each state . There is now a case presented for a mental health commission; see **"Australia needs a mental health commission" Rosen A. McGorry P. Groom G. Hickie I. et al Australasian Psychiatry Vol. 12 No. 3 September 2004** A body *"with direct access to Australian Health Ministers and all mental health service stakeholders, and which is also able to report independently from and to the government." (p2).* Such a commission has now operated for the last 8 years to reform services in New Zealand with considerable success and recognised beneficial outcomes. New Zealand is of course in effect one state only however the Rosen paper incorporates a mechanism to address the Australian structure.

(b) Resource Allocation and Future.
Suicides and homicide/suicide of known clients represents;

- the failure of the health system architects to appreciate the changing social patterns and trends and the increasing demands.
- the failure to plan effectively to meet those demands including the provision of sufficient financial resources to promote and deliver prevention and intervention and support programs.
- the failure of the direction for political action; that by improving mental health services the outcomes will be fewer harms and restoration of greater productivity.

An ongoing difficulty has been the insufficiency of funding for public and NGO services and lagging behind of cost of living increases and now costly administration and OH&S requirements. Worthwhile projects are commenced but can be discontinued when the funding term expires leaving the provider and service in danger of collapse.

Curtis
"Both government and NGO services seem to operate on a grant or award basis with little experience in standard contracting procedures, outcome measures or other common forms of accountability".

Effective efficient therapeutic mental health services properly resourced and adequately trained will achieve better outcomes in rehabilitation and recovery and a minimisation of the preventable suicide adverse incident.

6. Recommendation.
That a Mental Health Commission or similarly constituted body and as described in the above paper Rosen A. et al, be created.

7. Recommendation.
To ensure the delivery of effective mental health services in future planning and some parity with the mental illness population demographic; that funding allocated for mental health across jurisdictions be programmed to automatically increase on an incremental basis over five years to at least 16% of the collective health budget in keeping with international trends.

8. Recommendation.
Pilot programs that achieve their objectives be assured of ongoing funding while being subject to ongoing monitoring processes.

The Relevance of Suicide Data in Mental Health.

TOR (o) *The adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards.*

The Relevance of Suicide Data in Mental Health.

Data Confusion and Suicide Data as an Efficiency Measuring Tool.

Redefining the Definition.
Suicide is defined as (National Mental Health Promotion): *"A conscious act to end one's life. By conscious act it is meant that the act undertaken was done in order to end the person's life.").* By its very precision the definition excludes those who die by their own actions but which might never be determined as "suicide" by coronial authorities and the importance of the death and how we react to modify service provision might become differentiated, statistically displaced or dispersed and rendered useless.

ABS statistics carry the qualification "*when there is doubt about the intention of death suicides could be misclassified ……."* and *" The coroners may be reluctant to give a verdict of suicide because of the social stigma attached to suicides and the socio economic and emotional implications it could have on families of the victims".*

We prefer to use the terms "suicide and self-aided death (SAD)" because a distinction is needed to allow provision of supporting destigmatised services without having to argue about the legalities. The use of suicide absolutely as a descriptor of death is simplistic, limiting, exclusive, and dismissive of those who experience the same grief and trauma where suicide for a variety of reasons is not determined and families need the same support and aftercare services.

Actual examples:

- NSW. A young man who shot himself at Wallsend (Newcastle) in the street in front of his father after wounding a police officer with his own gun. Coroner; *"not suicide" "not capable of forming an intent to kill himself because of the influence of marihuana".*

- Western Australia. A man on a CTO from NSW who absconded from hospital and jumped from a transmission tower 3 days after being brought down by police from the same tower. Coroner (to make it easier for the parents!); *"not suicide" "death from multiple injuries".*

The Relevance of the Data.
In order for the data to be meaningful and relevant it must be uniform, up to date, inclusive, and able to be applied as a tool immediately within the mental health services and across jurisdictions. Suicide where people have not had contact with a mental health service and where there are suspicious circumstances or not, will still have to wait on the coroner, but delays ought to be rare.

Client Suicides as a Proportion of the Total.
In NSW, this proportion of suicides against the total in the state has risen from 10% in 1995 (Centre for Mental Health. Public Health Bulletin Vol. 6 No. 8 August 1995 J. Chipps et al), to almost 24% year end 2000 (CMH Mental Health Quality Portfolio Feb. 2002 and ABS #3303 Causes of Death Australia 2000 by state) and a suspected 30% plus in NSW from 2001. The original research on this basis was commenced by the Centre for Mental Health on my instigation in 1994.

The situation in country areas now with the worst drought in living memory is even worse with increasing rates of suicide that equates with the lack of adequate services over long distances and has been around 35% plus, (Central Coast Annual Report 1999/00/01) but is believed to be much higher today.

Suicide of Clients: The Service Efficiency Measuring Tool.
The proportion of suicides among people who are known clients of the health service or who have been identified at risk and been admitted to the ambit of the service by contact and assessment, is the most powerful measure of the ability or inability of the health services to deal with the syndrome of self-destructive self-harming suicidal behaviour in order to deliver an effective mental health service.

A Proper Description of Suicide.
Suicide and self-aided death (SAD) is frequently the final act of deliberate self-harm and despair in a mind dominated by the affects of a mental disorder or mental illness and/or substance abuse or an immediate overpowering emotional reaction to what is seen to be an unresolvable personal crisis.

New Description and Definition.
Suicide is death and does not need the tautology of "suicide death" in the literature and practice guides.
Suicide and self-aided death (SAD) is the consequence of self-harming thoughts or actions which eventuate in death, whether the criterion of intent as for "suicide" existed or not. This definition is realistic and practical and takes suicide (with intent) into account as well.
This description and definition allows the inclusion of remedial thoughts and bereavement grief support and action without the conflict of waiting for confirmation by the coroner.

Suicide Rates and a New Nomenclature.
The use of suicide "rates" to describe the event frequency to invoke public support has little meaning. Suicide must be referred to in terms of numbers related to communities and environments not as suicide rates. Because suicide "rates" are statistically low figures they dehumanise and depersonalise and are sometimes used deliberately by the service to disguise the nature and extent and reality of the problem of client suicides in mental health terms within area health services. To enable realistic planning client suicide data should be collected in all Health Department sectors and presented on the basis of numbers and not just "suicide rates".

Data Collection. Area Health Service Example.
In addition to MHOAT (Mental Health Outcome Assessment Tools) and electronic record keeping, Northern Sydney Area Health Service which until January 2005 included four acute psychiatric units but now six, has pioneered the collection of mortality data focusing on possible or probable suicide based on the reporting of deaths among known clients by their clinical supervisors. These data include last contact with the client, previous attempts, method used, inpatient or external, diagnosis, verbal or written warnings etc. It also separates the data according to the sector area. While still subject to a coroner's ultimate determination they are a much more accurate and contemporary source of information. However the same information is not kept universally for comparison across Areas but should be, and is not available outside the service being required to have coronial confirmation which occurs somewhere down the track, before forming part of the "official" figures overall.

Client Suicides.
In Northern Sydney the data is collected contemporaneously based on the clinician's or local service on-the-spot judgment and called "possible suicide" or "probable suicide" until subject to a suicide and/or other mortality confirmation by the coroner and out of comparative time.

What we are able to learn inter alia from these data most importantly is the proportion of suicides of known clients against the total in the state, or the Area Health Service, or even down to sectors so that it becomes a performance measure in itself as well as sighting and qualifying other deficient dimensions of care within the system. This performance measure deals more precisely in numbers and observes movement or lack thereof within a given area rather than rates per hundred thousand which become meaningless, and are conventionally used to publicly disguise the failures within the Area Health Service under the present system by appearing to be without fluctuation and therefore minimise the real occurrence of suicide.

9. Recommendation.

Adopt the proposed new definitions and standardise the client suicide data collection across jurisdictions to aid realistic planning and discovery of systemic problems.

Addressing Stigma

TOR (l) *The adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers.*

Addressing Stigma

Suicide & Stigma. A Change of Attitude

The Consequences for Service Provision.

In the late 90's the notion of responsibility for the act of suicide itself began rightly to shift from the identified person to a legal responsibility on society and the care-givers and service providers. Legal responsibility and accountability with the threat of punishment gained momentum, and began to supersede the conventions of the past. The outcome was a quiet shift in emphasis from caring for humanity to caring for and about rules, regulations, legal obligations, confidentiality agreements, codes of conduct, accreditation, privilege, and practice standards. There has been a shift of balance from protecting the person to protecting the staff.

Occupational Health & Safety requirements forced much of the attitude change as well as enforcing the regulations. (Extract from Parliamentary Inquiry submission 2002)

Opposing Forces and Working Apart.

The concept of duty of care and the obligation to intervene is now affirmed by legal force rather than natural humanitarian instinctual obligation. At the same time it has delivered a fear of litigation. Now the providers of care can be perceived by others to be at fault more definitively in order to be punished; responsibility-accountability or the avoidance of it has become a subtle overriding consideration. As a consequence the "therapeutic alliance" between the professional therapist and the person at risk is more difficult to establish. Notions of transference and countertransference can intervene in the alliance and produce negative reactions either way with the person at risk.

Policy in Relation to Carers and Caring Services. Stigma Leads to Discrimination.

Within the coterie of mental illness diagnoses families and individuals can feel isolated and dysfunctional because of stigma. Because they are not trained and are not professionals, their credibility as witnesses in making representations is often suspect.

From the carers point of view there is the fear of reprisal against themselves or their family member, and/or that their views will be demeaned and dismissed if what they see as unsatisfactory care by the service is challenged, particularly in the event of suicide or attempted suicide while in care. They have no status under the Mental Health Act, are frequently ignored or sidelined and without "rights" in relation to adult family members, and they have no authority to participate in the management determinations.

Mental health advocacy and participation courses for consumers and carers and positions as paid advocates are valuable services.

New Cultural Reasoning.

Culture change begets practical change. In medical misadventure we now have the Open Disclosure Standards. However with suicide the cultural reasoning is different i.e. the new mentality "*we didn't kill them… these people killed themselves"*. and *"we cannot prevent everyone from killing themselves*".

So we find reasons to justify poor service, lack of treatment options, and inadequate skills. There is a price conscious approach to care and we cannot consider the cost of making wards universally suicide inhibitive. We build fences on bridges; the Storey Bridge, Mooney Mooney Bridge etc. to prevent suicide and forget the cost yet we do not apply the same protective intellectual fence building approach to our inpatient units. So that such practical improvements as non projecting door handles and equipping inpatient units with closed circuit TV etc. are seen as a cost not a benefit, and an invasion of privacy. The most cost effective outcome after all is the mortality of clients; dead people are not a cost to the service.

Outcomes and Unforeseens. From Hospital to Community Care.
Over the last 15 years these new forces have had unforeseen consequences:
In a litigious society fear of litigation compounded by a duty of care requiring therapists to enforce involuntary admission if the client appears to be at risk. As a consequence it can be difficult to establish trust and acceptance.

- Separation/distancing from the patient/client's interests e.g. from the introduction of OH&S requirements and transfer of welfare concern from the client to the service provider.
- Increased negative attitudes and inhibited interactive unsympathetic responses to client needs.
- A tendency of management to divert from the issue by focusing in their discrete manageable/controllable environments on *suicide rates* instead of the *actuals* and *suicide numbers*.
- Favoured protection of the service provider or agency at the expense of the client.
- **Concepts of accountability have in themselves accelerated the incidence of suicide in care.**

Admission.
Dr. ….was there. She knew me from previous occasions and seems to have a disliking towards me. She said do you want to kill yourself? I said yes and she said "go" meaning get out of here. The police told me no, not to do this but to ask for help. When I did the doctor said what is the point. I was crying and she said words to the effect: you cry, you cry, you want sympathy, no sympathy for you. Even the police were shocked. She looked at my arms which had a couple of burns and seemed to be disgusted. She made out that this was attention seeking I had not been trying or making an effort. T.K.

Stigma is like airborne bacteria it spreads discrimination.

10. Recommendation.

- The inclusion of families, carers, and significant others in the legal framework of intervention, support, rehabilitation and recovery.
- Carers to be given appropriate status and formal recognition under legislation to enable them to take an effective role in the management of their adult family member.
- Institute a program to ensure that therapists/health workers are effectively trained in how to build relationships and redress inappropriate attitudes.
- Mental Health Advocacy and participation courses for consumers and carers and positions as paid advocates are valuable services.

Duty of Care

TOR (k) *The practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;*

Duty of Care

Refer to Tarian Kiana's letter.
Seclusion.
Inappropriate use of seclusion can be dehumanising. Tarian reports being placed in seclusion many times, she says "lost count"; literally forced into the room with several staff to overpower her and dragged and injected, or sometimes voluntarily. But she recognises that when it happened she was unmanageable and self-harming hitting her head and that it would also have been to ensure safety to others or to avoid distress to them. Sometimes the door was open and it was a time-out situation.

She also says that in her experience in some hospitals it is a power thing to threaten punishment and control.

Hospitalisation.
The following day I was seen by a male doctor who approached me in a common area and started to discuss my issues. I felt that this was inappropriate. He asked me did I feel I needed to be in hospital, to which I replied that I thought I did, as I felt unsafe within myself and scared. Before I could say anything else he said (words to the effect) how dare I put it on the hospital to make me feel safe and that there was nothing they could do for me and that I was beyond help. I started to cry and said you don't care do you? He looked at me with what I interpreted as a look of indifference and I said f##k this I am leaving. He said that he wouldn't stop me and that was that. I left crying uncontrollably feeling as though no one cared and that I was a waste of space. It was after this occasion that I decided that I would never go to hospital voluntarily again. T.K.

Of hospitalisation.
It's one thing to have your freedom taken away or restricted because you are deemed to be mentally ill disordered or a danger to yourself or others but once we are in these psychiatric facilities we should not be treated as second class citizens. Taking the time to spend 20 minutes sometimes shorter/longer to listen to a patient goes a long way. You can feed them medication, lock them away but that does not necessarily solve the problem. I know it can be frustrating to see a patient come through what seems to be a revolving door and its easy to say they must not be helping themselves when your attempts of helping them does not solve the problem but all I can say is that I am trying. I don't enjoy the feelings I have, the pictures in my head, the flashbacks or the fact that I do self harm and being perceived as if I am playing a victim. T.K.

Staff Considerations.
There is a need to make the profession's image and growth attractive for staff in order to recruit and maintain good staff.

At the same time as great concern is needed for persons in care in hospital environments it must be recognised that staff are under considerable workload pressures at times, staff shortages, difficult patients etc., and these pressures can be multiplied by personal issues outside the job. Staff need the opportunity for respite by rotation and time-out periods, or a program being built into the system as well to attend training programs.

Continuation of Duty of Care.
From our experience in mediation and advocacy following a suicide in care as well as our experience from our Open Disclosure Support and Advisory Group most families although feeling damaged by the failure of the system do not want to pursue litigation for compensation. They merely want to contribute in some positive way to try to prevent others experiencing the same devastating debilitating grief. The experience of mediation and litigation can be absolutely emotionally and physically draining and may not achieve the outcome in their traumatised state they believe they would like. The service is able to trade on this devastation. Our organisation was threatened and asked to discontinue our group under the title "Open Disclosure". There were some 29 people representing families all having experienced a suicide and most of them while in care or as known clients.

Client Suicide in Care. The Service Response.
Suicides in care should be an extremely rare event. Under the principles of Open Disclosure the service should immediately express regret and condolences (without prejudice) and offer financial support to offset the expenses that will be thrust upon the family and ongoing professional grief counselling and medical, psychological and social support to all family members as required for say 3 years via practitioners of choice of the family. The suggested amount for an ex gratia payment is $20,000.

Case E Suicide list. An example that the substantial settlement did not mean anything to the family.

We believe that such a process will have more positive outcomes;

- A positive assistance to the family.
- A genuine recognition that the family will have substantial unforeseen expenses.
- Less resort to litigation and costly compensation.
- Reduce the perpetuation effect and prospect of further suicides.

11. Recommendation.

After a suicide in care under the Open Disclosure practice, the service immediately express regret and condolences in writing and provide the financial, medical, psychological, and social welfare support etc. as above.

12. Recommendation.

Seclusion is an appropriate and necessary adjunct in the acute ward but needs to be utilised appropriately with discretion and not as a power or punishment mechanism.

13. Recommendation.

Establish time-out and respite arrangements for mental health nursing staff in hospitals to allow for comforting interaction with patients and ensure that standards are set to ensure that patients are not subjected to reductive language.

The Building Blocks of Community Service
Building NGO Capacity

TOR (d) *The appropriate role of the private and non-government sectors;*

The Building Blocks of Community Service

Building NGO Capacity

The Role of Non Government Organisations.
The environment in NSW has been inhibitive of the growth and encouragement of mental health NGO volunteer, not for profit, and community agencies. It has sometimes been only the dedication, energy, and the contribution of substantial personal and private resources that has enabled them to maintain the operations. The government preference is seen to be moving to fund the major charities rather than specific mental health NGO's and similarly to centralise and contract and withdraw rather than outreach mental health services.

Curtis
Concerns were expressed about potential use of "people-based" outcome measures for mental health services because "people are too complex." Further there was a belief that NGOs are inherently accountable "because if we are not, we are out of business. Government is always funded -- you cannot de-fund government – so they do not need to be accountable."

NGO's provide immensely valuable service on a less costly basis than the public services. This is partly due to the multiplier effect from the utilisation of volunteers. Depending on the size and make-up of the organisation its type of service and the nature of the project, and because they raise funds privately, this multiplier can range from about 3x to 20x. the face value of funding or grants provided.

Undesirable Reversions to the Public Service.
In one Health Area a review is being undertaken with an accommodation service to transfer clients from the NGO case management to the control of Area Health staff. It is estimated that such a move will escalate the cost of management from around $30,000 per unit to around $70,000 due to the anticipated increase in work loadings of the staff and an escalation in morbidity factors with the clients under that kind of management.

Small NGO's.
Many small but invaluable NGO's and community agencies raise their own funds to keep providing the entire volunteer service they offer. In addition they provide financial support to the funded health services. These services are very often provided without the benefit of their own computer or other office equipment such as photocopiers etc. and rely on borrowed facilities. Many use up their own personal resources and subsidise what they believe in from their own income. Units such as East Wing and the Cummins Unit and others have benefited from monies raised by these groups to subsidise the Health Department.

Curtis.
"Participants from NGOs believed that there were few, if any services currently provided by the government that could not be effectively delivered by a NGO. However, focus group participants were also not particularly interested in contracting with NSAMHS, fearing government control of their services, e.g. "They want us to do what we don't want to do."

Examples: Action Foundation for Mental Health, Hornsby Ku-ring-gai Association, Service Users North Shore, Northern Beaches Mental Health Support Group. (Extract from Parliamentary Inquiry submission 2002)

NGO Funding. Competition and Resistance.
In NSW funding applications from NGO's go through a complicated time consuming process between the Centre for Mental Health, the Health Department itself and the Area Health Service for consideration and recommendation with many stages of backtracking and approval and further backtracking. Area Health Services have a conflict of interest as both a provider of care and as a funding body. This sets up competition for funds in some respects between the NGO and the Area which must sign off on every funding application before it goes to the Minister and after Ministerial approval and may change the deal after earlier approval.

In addition it can impede, obstruct or defer or fail to support funding for bodies that may be a voice for those failed or disadvantaged by the service and contribute to the image of favourites or lack of transparency. There are similar delays when the funding term comes up for renewal creating huge uncertainty and the prospect of having to put off staff.

NGO Centralised Funding Body.
These issues would be avoided and processes streamlined if all NGO funding proposals were handled by an independent and impartial body set up within the Department expressly to service funding needs and applications. Area Health Services could continue to monitor the programs.

Consumers and Carers and the Value of the Caring NGO Club.
The Mental Health Association NSW has been the proprietor of depression support groups since the 80's. It ran a funded demonstration project 2002 –2003 to assess the value of support groups and assist other agencies to establish their own. An excellent how-to video was produced. ARAFMI and Schizophrenia Fellowship have operated support groups in different areas for some years. Each has been specific to their core function.

Support groups of consumers and carers are important adjuncts to growth and recovery or simply to help maintain stability through being in the company of like-minded people who share similar experiences or similar grief associations. This is especially important in relation to suicide, attempted suicide, or combinations of those. Support groups explicitly are not therapy groups nor do they use group therapy but the outcome of the caring interaction can be extremely therapeutic. Participants are able to express their deepest concerns and most personal revelations without judgment. NGO's are able to provide these supports much more effectively than the mental health services because in many instances participants report bad or unhappy experiences with mental health services or hospital environments which inhibits the sharing interaction if service personnel are present, except by invitation for a special purpose.

Groups can fluctuate in attendance and not everyone wants to continue for a long time, however very often it seems that the group has achieved its purpose and the participants are able to move on. There are those however who continue because they want to see others getting the same support that has benefited them. Sometimes people need to revisit the group to renew acquaintances or reinforce the benefits or because they have grown to the stage where they want to help others.

The Suicide Support Group.
Club SPERANZA has had 10 years experience in this special type of support group incorporating people who have attempted suicide or have experienced a loss or are at risk or who share all three and mostly some kind of mental illness is a feature of their experience. SPERANZA has designed a special protocol for conduct and set of rules. It has conducted more than 250 such groups and as well special purpose groups e.g. a group of 15 medical practitioners mostly suicidal and under review with the Medical Board because of complaints and allegations of malpractice. SPERANZA holds many written testimonials which attest the value of the experience of the group members and the belief that their lives have been turned around as a result of the association.

In the beginning and over the years concerted attempts were made by the service to discourage such a combination in a working group environment because of the expressed fear that multiple suicides could result. Funding from mental health sources was denied.

14. Recommendation.

- Introduce a small grants subsidy scheme for voluntary NGO's. including start up funds.
- Initial subsidies on a one-off basis up to $10,000.
- Provide start up funding, growth money; ongoing low level recurrent income support to build infrastructure.
- Establish a funding pool to allocate infrastructure support for agencies able to demonstrate the effective and consistent operation of support groups especially for those at risk of suicide or bereaved by suicide.

15. Recommendation.

- To certify the equal place of NGO's in the health funding hierarchy and properly develop community based care; to elevate incrementally over five years the proportion of mental health funds allocated to NGO community based care from 2-3% to 20% of the mental health budget.
- Establish centralised specific NGO departments to assess NGO funding needs and process applications until actual funds transfer to the organisation.

Workplace and Community Education & Training.

TOR (g) *The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness.*

TOR (i) *Opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated.*

Workplace and Community Education & Training.

Background.
SPERANZA has had experience in developing public and private mental health and suicide awareness and intervention skills training since 1991 through its working association with Lifeline branches and the creation of the Australasian Association for Suicide Prevention and later, Suicide Prevention Australia, NSW Health and the Commonwealth Department of Health. SPERANZA pioneered public community mental health/suicide awareness meetings from 1994 in a style now promoted by Rotary since 1998.

Attributes of Training.
Training in suicide awareness and intervention must be simple, capable of being readily absorbed and practiced by health workers and non-professionals alike and build confidence to work and interact with those in despair and with challenging behaviours to overcome the fears or indifference that the prospect of suicide creates.

Curtis (Northern Sydney Review) refers to the use of language and terminology in relationships and documentation and notes the poor understanding of the difference between rehabilitation and recovery and these issues and makes recommendations about changing the culture and for "*respectful, non-reductive language*" the "*impact of hope, positive expectation, and language in helping relationships and recovery*", revising documentation, and training of all staff.

Best Practice Training.
Unfortunately with suicide intervention training services often attempt to design individually something "better than the others" which ends up wasting money. LivingWorks Applied Suicide Intervention Skills Training (ASIST) auspiced by Lifeline is the internationally recognised, evaluated, and updated training program of choice that best meets the criteria and in addition to address effectively the inappropriate attitudes to suicide and suicidal people that strangely enough can be a characteristic of many professional health workers as well as members of the community. It is being used extensively around the world and in most states with the exception of NSW. The Australian Defence Dept. has just completed a train the trainer program.

Tarian Kiana's letter illustrates very forcefully the type of improper response to someone in acute distress in the very place where understanding and care should be the primary expectation.

On attitude.
I feel the behaviour and conduct displayed in these instances to be unprofessional and detrimental to myself. I have talked to many psych. patients and I am not alone. The system is supposedly set up to help people with mental health issues but I guess people like me fall outside what they want to deal with. I hope that the attitudes and conduct of the doctors and staff within the system that are on the front line can be changed as they are doing more harm than good. T.K.

Seeking help.
The following day I still felt the same. I rang mental health and explained what had happened but they seemed not interested and even though they said (words to the effect) you don't still feel like harming yourself and I did, I felt what was the point. What could they do? Send me back to hospital where it is obvious they feel I am beyond help. T.K.

Attitude.
The issue of attitude is one of the most important in the training of those who work with people at risk of suicide. Personal issues must be set aside and be able to be set aside. Example: A health worker who has resolved personal issues within themselves but is called in to confront working with and establishing a life-saving relationship with a paedophile. Other instances may not be as dramatic as the above but can be just as damaging in the therapeutic alliance or failure to establish it. LivingWorks spends considerable time in addressing these issues.

16. Recommendation.

Introduce a national uniform LivingWorks Applied Suicide Intervention Skills Training and train-the-trainer program.

The Case of Matthew Oakes. Case B. List of examples.

The submission to the NSW Inquiry of Mrs. Diane Oakes (a qualified nurse who trained in Manly Hospital), in relation to her son Matthew Oakes who died by hanging at Manly Hospital, illustrates not only a huge failure in care both within the hospital and outside it and a mindset against providing treatment, but a complete disregard of the opinions and experience and in this case the professional experience of the carer/s.

This case (and others) is a significant personal example of:

- The failure to appreciate the value of the "carer" and family knowledge and experience.
- The fact that there is no consistency and uniformity in the management of people at risk of suicide even in the hospital environment.
- That there is no uniform protocol for management and follow up.
- That the criteria for risk assessment relies on subjective assessment rather than objective facts i.e. the fact of the attempt itself.
- The division between the mental illness treatment service and the substance abuse rehabilitation (MISA) service.
- That there are no facilities for ongoing care in an asylum environment.
- That there must be a range of treatment options available in addition to medication e.g. more particularly, Cognitive Behaviour Therapy (CBT) and Dialectical Behaviour Therapy (DBT) and physical health rehabilitation.

17. Recommendation.

Carers, families, formal carers networks and consumer networks are important and integral support mechanisms. Carers and consumers must have equal status and consideration in the preparation and operation of the client management plans and aftercare support.

18. Recommendation.

Carers must be allowed greater financial support and access to benefits.

Suicide Risk Assessment.
Admission, Discharge and Community Management.

TOR (o) *The adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and*

TOR (m) *The proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;*

Suicide Risk Assessment.
Admission, Discharge and Community Management.

Confusion and Complexity.
The Framework for Suicide Risk Assessment and Management for NSW Health Staff September 2004, is a massive document that perpetuates some of the original flaws in the earlier misconceived Circular 98/31.

The Paradox of High Risk and Low Risk, or No Risk.

The Framework document sets out the risk assessment protocol based on the terms "high" "medium" and "low" risk. Although there are built in qualifiers to allow for changeability it means that complexity rather than simplicity and commonsense is introduced, and the opportunity to apply the "least restrictive environment" provision is introduced with the potential for detrimental outcomes.

What we have, is a complex pretentious 40 page study manual nominating every possible factor and consideration that might conceivably have some association with a disordered mind and candidate for suicide. For practical purposes it is unsuitable. It is like the library not the reference book; the entire thesaurus instead of the needed word application.

What is required is, (a) a simple practice guide in three sections with simple clear statements setting out the steps to be taken at admission or first contact, while the person is in care and on discharge with a takeaway section for the family or support person and **(b) a clearly set out form and check list** showing the pathway of treatment and support within the hospital and following discharge in association with the community services.

Over the years in workshops and directly to the authorities overtures verbally and in writing and in committee met with the responses up to the highest Area level and within CMH and from clinicians that illustrated the meaningless oxymoronic confusion, such as, ***' "high risk" doesn't mean high risk, it can mean low risk'*** (a psychiatrist mental health area director) 'We aren't going to change it! You don't know what you are talking about.'

If a person comes to attention of the service because there is a stated risk of suicide or the person feels unsafe <u>they are "at risk", not high medium or low</u>!. Sure the condition is variable but the person is at risk. It becomes a matter of therapeutic management, not confusing terminology.

<u>In our experience with hundreds of people at risk of suicide, the concept of high medium and low risk as descriptors of suicide risk is anachronistic and the descriptors themselves in practical application are confusing and a contradiction in terms.</u>

<u>In practice, clinging to outmoded terminology continues and perpetuates the confusion and becomes self-deceiving and impractical in application but worse still leaves the person open to misinterpretation of suicide state. The updated, evaluated, and internationally recognised suicide intervention skills training program LivingWorks ASIST has dispensed altogether with these descriptors.</u>

Suicide. The Medical Emergency.
Staff in Emergency Departments are often inexperienced in working with people with mental health problems and unofficially assign them a lower priority for attention. Sometimes people get tired of waiting and walk out still at risk. The Framework mandates that the prospect of suicide and with a person at risk must be considered to be a "Medical Emergency".

On admission the medical and physical condition must be taken into account at the same time as the mental health assessment. As well as the other considerations it is appropriate that as a medical emergency the terminology and the mental association should be compatible with and alongside other Emergency Department classifications i.e. “critical” “stable” ‘’out of danger”.

Appropriate Terminology.
The terms “crisis” “crisis abated” “stabilised” and “no foreseeable risk” meet the compatibility criterion and are simple and well understood by anyone with minimal training and experience. They also convey accurately without debate the state of mind of the person. In combination with a proper mental health assessment and rating method and physical assessment they would be much more effective and reliable.

19. Recommendation.
Replace “high” “medium” and “low” descriptors with “crisis” “crisis abated” “stabilised” “no foreseeable risk”. Until by consensus clinical review the person is “stabilised”, observation in safety conditions must be continued until there is no foreseeable risk.

20. Recommendation.
Ensure that the recommendations of Tracking Tragedy 2 or similar in relation to community follow up are implemented across jurisdictions.

(At the very moment of writing these statements I was contacted by a distressed person in crisis with a history of sexual assault and PTSD. She had made two attempts to obtain help from the mental health team to be admitted to hospital in order to be safe and was declined with comments like “you might not get the noose right if you try to hang yourself”. This exchange begs the question what was the level of risk assigned to this person at this time?)

I called the police who agreed with her condition and accompanied her to hospital with the police to ensure admission. She was assessed and admitted by a psychiatrist because she was found to be unwell.

Community Mental Health; the New Vision.

TOR (i) *Opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;*

TOR (m) *The proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness.*

Community Mental Health; the New Vision.

The Mental Health Service Hierarchy and Public Image.

To give mental health its rightful and publicly perceived place in the Area Service hierarchy and avoid diversion of mental health funds, a recommendation from the Parliamentary Inquiry was that Area Mental Health Directors should be level 2 appointments, control their own budgets and report directly to the CEO. This has not been implemented and they remain level 3. In North Sydney's case the Area Director formerly under the Director Nursing and Community Services, (absurdly) will now report to and be subsumed under the Director Clinical Operations. Mental Health is not the specialty of Clinical Operations.

21. Recommendation.

Ensure that Mental Health Area Directors or their equivalent in other jurisdictions have equal status with other Directors at Level 2.

Meeting the Standards. Preventing Failure.

(Extract from Parliamentary Inquiry submission 2002)
Quality control is a function of good management structures and effective processes and procedures. It also depends on good working relationships. Often standards can be established and rules of operation introduced but for various reasons the standards cannot be met because of a factor or factors hidden, disguised, or unnoticed so that it is not possible to comply. The listed case examples of client suicides and particularly "A" & "B" illustrate that in one or more respects the service has failed those people and others in its care because although people knew what to do there were slip ups and no fail-safe controls. The study of 65 client suicides "Tracking Tragedy" chaired by Prof. Peter Baume AO reveals that it was more by good luck than good management that there were and are not more suicides.

We frequently hear the response after a death and during or after the review or mediation process *"the system is not perfect"* as if this can justify what has been shown to be ineptitude, poor assessment, shortage of staff, human failing, lack of qualifications, inexperience, poor management practices, lack of direction, etc..

Compliance Managers.
Companies have compliance managers to ensure that the company is not vulnerable to failure through ignorance or neglect or inability to operate within its legal and prudential financial boundaries. The armed services are instituting a similar position. Destabilising of the staff and the service happens when families, consumers, carers and patients make serious complaints particularly after a suicide in the unit where the staff can be held accountable.

Whilst we have standards set by arbitration and experience with the exception of distantly separated "accreditations" and audits, we do not have a mechanism to determine and identify circumstances or conditions prevailing which might lead to those failures before the event. The introduction of the new OH&S requirements, whilst being an unfunded cost and accountability imposition particularly on NGO's, has drawn attention to the nature of the problem.

A Review Process.
Rather than distant accreditation and incident reviews after the event, there is a demonstrated need for a preview process in Area Health Services to;

- inspect and report conformity and compliance of the operations of public, hospital, and community services in relation to established Area mental health policy .
- discover/isolate systemic problems
- assess the factors which create an inability to comply with the service standards, best practice, and accepted duty of care.
- make recommendations to remedy deficiencies on a priority basis.
- improve the predictability of areas of failure which might lead to death or misadventure.

22. Recommendation.

Appoint Area Health Service Mental Health Compliance Managers across jurisdictions.

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Attachments

Biography. Tarian Taniwha Kiana Age 29

Tarian is a person who has been sexually abused by her stepgrandfather a war veteran who died and neighbours her earliest recollection being from the age of 2 to age 9, which raises unpleasant associations on ANZAC Day anniversaries in particular. She suffers from PTSD and frequent flashbacks from this abuse and being raped on another occasion. At the age of 16 she was witness to a murder where the victim was beaten to death. The case took 4 years to be finalised in court. She became a State Ward and lived in youth refuges. Tarian has a mental health services case manager and lives in community housing. She has had many hospital admissions over the years and is presently on a disability benefit while studying 2 days per week at TAFE with a year to go in her course.

To whom it may concern May 2005

My name is *Tar*ian Kiana and I am writing this letter in hope that it may help lead to substantial change for the better within the mental health system of NSW. I have written many unsent letters scared that one voice, especially mine would not make a difference but thanks to the advice of a few who have heard my story this letter sits before you today.

Presently I am 29 years old and have been diagnosed as having PTSD, Depression and now Borderline Personality Disorder. I was sexually abused by my stepgrandfather over a period of eight years and on ANZAC Day anniversaries particularly I become suicidal and disabled with flashbacks and nausea. I have been sexually assaulted on other occasions with similar associations around New Years Day.

My first psychiatric hospital admission was at the age of 16 after an OD when I was in a youth refuge because of this abuse, and over the years because of this history I have spent various durations of time in numerous hospitals. I often present to hospital in a distressed agitated, and commonly suicidal condition and will often self-harm by burning myself on the arm and by banging my head. Various hospitals handle me differently from one another.

When I was 24 I had shock treatment which was OK in the treatment but affected my short term memory so that I could not remember the study work of that semester and I could not remember how to drive for a while.

I am especially unhappy with the treatment I have received over the last year and a half. Some examples are as follows:

Mid to late 2004

On this occasion I had spoken to Lifeline who then in turn spoke to mental health. They came and took me to Missenden. The doctor I initially spoke to seem helpful and interested and decided to keep me on a temporary 3 day mentally disordered order. I stayed in the open ward. The following day I was seen by a male doctor who approached me in a common area and started to discuss my issues. I felt that this was inappropriate. He asked me did I feel I needed to be in hospital, to which I replied that I thought I did, as I felt unsafe within myself and scared. Before I could say anything else he said (words to the effect) how dare I put it on the hospital to make me feel safe and that there was nothing they could do for me and that I was beyond help. I started to cry and said you don't care do you? He looked at me with what I interpreted as a look of indifference and I said f##k this I am leaving. He said that he wouldn't stop me and that was that. I left crying uncontrollably feeling as though no one cared and that I was a waste of space. It was after this occasion that I decided that I would never go to hospital voluntarily again.

2004

After a brief stint in RPA for a Largactil overdose it was decided that I should go to Rozelle voluntarily. I had taken the Largactil because I just wanted to escape but if I had died it would be a bonus. I was still heavily under the influence of the drug and was therefore very groggy so I agreed to stay. The doctor did not seem interested and if anything spoke to me about getting a job. As in this particular open ward you could not go to bed in certain hours I laid on the couch. I was dressed in summer clothing and as the afternoon wore on I was feeling cold. When a nurse passed the loungeroom I asked for a blanket and she replied (words to the effect) its not a bloody bedroom and walked off. At the time there were no activities on and several patients lay asleep on the floor. It seemed they were left alone for a while and then when it appealed to the nurse she would nudge some of the patients and with a raised voice say they couldn't sleep there. I ask you what were they meant to do?

2004

Over the year I had several hospital admissions at Rozelle. I know some people find my self harming behaviour offensive and it became clear that several staff were displeased with my arrival. Sometimes I would come into the admissions room hearing the staff discuss me saying things like not her again. This made me feel as though they thought of me as a joke.

Feb 2005

On this occasion the police found me in Five Dock upset and I was self harming. The female officer recognised me as she had pulled me out of my car a few weeks earlier as a result of a failed suicide attempt. The police took me to Rozelle psychiatric hospital. A female doctor that I now know to be named Dr. ….(name supplied) was there. She knew me from previous occasions and seems to have a disliking towards me. She said do you want to kill yourself? I said yes and she said "go" meaning get out of here. The police told me no, not to do this but to ask for help. When I did the doctor said what is the point. I was crying and she said words to the effect: you cry, you cry, you want sympathy, no sympathy for you. Even the police were shocked. She looked at my arms which had a couple of burns and seemed to be disgusted. She made out that this was attention seeking I had not been trying or making an effort, but I beg to differ.

23rd April 2005

On this day getting near the anniversary of my grandfather's abuse I was handcuffed and taken by police in a distressed state to Rozelle psychiatric hospital. The police were called as a consequence of a conversation I had with a person from Lifeline when I said I was suicidal. They may have assumed that I was a danger because they saw a box cutter on the ground. Upon arriving I was welcomed with comments such as not her again. Dr …. a female doctor was present with whom I shared many unpleasant occurrences. On this occasion I heard her say to the staff let her go but then it was decided we would have a brief chat. I was upset and tried to explain but her comments led me to believe she did not care. She more or less stated that everything that could be done for me had been done and that hospital was no point despite the fact that hospital admission is in my case-management plan that I hold with Camperdown mental health Service. She then told me that when I spoke to Lifeline not to tell them that I felt suicidal (words to that effect) and when I said that was how I felt she looked at me and said it wasn't. I then thanked her for being of no help and admit to saying a few harsh words. I was left to make my own way late at night in a very distressed state. I was scared to call lifeline and ended up staying at a friend's.

The following day I still felt the same. I rang mental health and explained what had happened but they seemed not interested and even though they said (words to the effect) you don't still feel like harming yourself and I did, I felt what was the point. What could they do? Send me back to hospital where it is obvious they feel I am beyond help.

I waited till the early hours of the following morning and I tried to kill myself in my car with hoses connected. I had prepared the car inside with photos and mementos. I was found and awoke in RPA on the 25/05/05. A psych person I think named …… S came to talk to me. As I was upset she gave me some medication. I tried to explain my situation, how I was feeling not just the issues surrounding the main reasons I felt like suicide but the anger and mistrust I felt towards the mental health system. She said that what I had done was serious and that I should spend some time in Missenden. I said no but I was taken there. (I understand this). I told her I was scared at how I would be received and perceived by the doctors and nursing staff but she said it would be okay. She took me into the observation ward at Missenden and some staff placed me in the seclusion room. They gave me a needle which I thought was meant to relax me, calm me or give me some relief from my racing thoughts. At no time did they say they were transferring me to Rozelle.

At some point I awoke on some form of hospital bed being wheeled somewhere. The next thing I know I am at Rozelle. I find myself in a room with a female doctor in a groggy state and her saying I need to sign myself in voluntarily. I thought that if I didn't sign what would I do as I was in no state to find my way home. Anyway I guess the doctor realised I must have been scheduled as I did not sign anything. I went to bed and awoke the next morning. I spoke to a nurse in Rozelles observation ward and admit to having a bit of an attitude. I was feeling hopeless.

They gave me something to eat at breakfast but I was sick as a result. I asked for something to settle me but to no avail. I laid on my bed and the doctor came to see me. I told her I know they don't like me in hospital and she said I looked so much better. Was this her subtle way of telling me that I was fine and my crisis was no longer a crisis. I felt as though they wanted me out and it was true I am beyond help. I said I would leave and even though she said I could stay another day I felt as though what's the point?

I feel the behaviour and conduct displayed in these instances to be unprofessional and detrimental to myself. I have talked to many psych patients and I am not alone. The system is supposedly set up to help people with mental health issues but I guess people like me fall outside what they want to deal with. I hope that the attitudes and conduct of the doctors and staff within the system that are on the front line can be changed as they are doing more harm than good.

Although I have expressed some of the problems I have had with psychiatric hospitals such as Rozelle and Missenden I would like to let people know of the positive in hope that others may see the benefit of such application.

From approximately 2000 – 2004 I was under the care of a psychiatrist named Duncan Wallace who I think was the head Dr. at Caritas. During this period I spent a lot of time in Caritas with my longest admission being about 7-8 months. Even though we had some disagreements he was a doctor that treated me with respect and dignity. In fact everyone at that hospital did. I have heard the speeches of staff shortages and funding shortages but I don't think there was a day I felt as though they thought I was beyond help or a joke.

I have been given a statement of patients rights at times. With the exception of Caritas I have not had any avenues of complaint explained to me such as patient's rights, official visitors, consumer advocates, patient support officers. The one time I did have a disagreement and words in Caritas over a nurse's actions it was addressed by their staff which varies from Rozelle. I have had nurses make smart ass comments or comments such as "look you bloody can't do that here, once you get out I don't care what you do". The way Caritas dealt with me when I self harmed was a lot different. They didn't seem to despise me like some at Rozelle and Missenden. They have sessions where they tell you about official visitors and making complaints.

The nurses interacted with the patients more at Caritas from what I observed as opposed to Rozelle and Missenden. The activities Caritas had and the staff implementing them seemed to work for most but I guess the biggest positive thing was their interaction with patients. Unfortunately Dr. Wallace left Caritas and because of geographical boundaries, which define what hospital a patient can go to, the support I received from Caritas was discontinued.

Its one thing to have your freedom taken away or restricted because you are deemed to be mentally ill disordered or a danger to yourself or others but once we are in these psychiatric facilities we should not be treated as second class citizens. Taking the time to spend 20 minutes sometimes shorter/longer to listen to a patient goes a long way. You can feed them medication, lock them away but that does not necessarily solve the problem. I know it can be frustrating to see a patient come through what seems to be a revolving door and its easy to say they must not be helping themselves when your attempts of helping them does not solve the problem but all I can say is that I am trying. I don't enjoy the feelings I have, the pictures in my head, the flashbacks or the fact that I do self harm and being perceived as if I am playing a victim.

With my PTSD I don't like the feeling of not being worthy of treatment and understanding as I would be if I was a war veteran. Or being told if you are going to do it do it don't call Lifeline. Or that you are only just sad. The depths of despair, hopelessness, sadness, fear, anger, depression. These are real to me.

My current case manager is alright to me. I see her once a week and I know she does listen to me but I feel people like her are in the minority. I have been told by some that maybe hospital isn't a place for me but where am I supposed to go when death seems like my only viable option.

At the end of a day any system mental or otherwise can have an ideology, guidelines, practices that are supposed to be in the best interests of themselves, clients and society but the service will only ever be as good as those who implement them and those that are on the front line. If present/past or even potential clients are scared and/or angry at the way they have been treated by the Mental Health System how can it be positive for them or their family and friends.

Thankyou for your time
Tarian Kiana

The Curtis Review

"Psychiatric Rehabilitation in Northern Sydney Area Mental Health Services" A Review and Analysis of System Performance Conducted for: Northern Sydney Health Area Mental Health Services. Report submitted: July 2001.
This review is referred to as the "Curtis Report"

Rational Funding of NGO's

Extract from the Curtis Report.

NGO's Concerns.

Curtis in her Review consulted with significant NGO's some resident in the Area, and explored the issues of partnership and NGO financial support and better collaboration between government and non-government organisations in the Area.
Concerns raised included the following. **Extracts:**

- *"Perennial under-funding of all mental health services, and in particular those services offered by NGOs.*
- *Concerns that devolution of funding authority from CMH to Area Health Services will result in further reductions in funding to NGOs. Beliefs that funding currently available to NGOs through CMH will be diverted by the Area to fund government services.*
- *Beliefs by NGOs that government operated services see NGO staff as non-professional and untrained.*
- *Overall lack of support in Area for NGOs, lack of recognition for NGO ability to deliver services "on a shoe string" budget, and disregard for creativity and initiative shown in NGO sector.*

"Participants from NGOs believed that there were few, if any services currently provided by the government that could not be effectively delivered by a NGO. However, focus group participants were also not particularly interested in contracting with NSAMHS, fearing government control of their services, e.g. "They want us to do what we don't want to do." It is unclear whether this sentiment is representative of the non-government sector throughout NSW or primarily a reflection of personal attitudes within these NGOs. Both government and NGO services seem to operate on a grant or award basis with little experience in standard contracting procedures, outcome measures or other common forms of accountability. Concerns were expressed about potential use of "people-based" outcome measures for mental health services because "people are too complex." Further there was a belief that NGOs are inherently accountable "because if we are not, we are out of business. Government is always funded -- you cannot de-fund government – so they do not need to be accountable."

Tony Humphrey

Twenty five years in health promotion and association management, Health Department, and service committees and boards such as Council on the Ageing. Eight years developing health promotion and lifestyle education programs for NSW Health and Australian College for Seniors particularly related to senior adults. Member of the Healthy Older People Project NSW Health. In 1991 chaired review of the NSW Institute of Psychiatry.

In 1985 daughter Michelle suicided, age 23.

President and co-founder of Club SPERANZA (Australian Mental Health Suicide Consumer Alliance) est. 1994
Vice President, Mental Health Association (14 years as chairman or deputy chairman).
Board member Mental Health Coordinating Council.
Past Board Member ARAFMI.

Northern Sydney Area Health Service.

Chairman: Mental Health Community Consultative Committee, 7 years
Member: Suicide Prevention Standing Committee
Acute Services Planning & Advisory Committee
Child & Adolescent Committee and Reference Groups
Instigator of Carers Network.

Six years Australian National Association for Mental Health and formation of Australian Psychiatric Disability Coalition (APDC).

Founding executive vice president of the Australasian Association for Suicide Prevention 1991 later merged to become Suicide Prevention Australia (SPA) three years as the first national committee consumer member of SPA.

Club SPERANZA

Report Card

SPERANZA Centre

Club SPERANZA since 1994 as a volunteer organisation and mental health advocate is a pioneer and major contributor to community awareness and suicide and self-aided death (SAD) minimisation. Its activities include.

Support for people at risk and bereaved.

Conducted around 250 regular consistent inclusive support groups at community centres with inbetween personal support availability and worked closely with mental health services to turn around people at risk of suicide and offer support for bereaved families.

Conferences, seminars, public meetings etc..

- **"The Tragedy of Suicide",** with presenters including Professor Ian Webster AO, Dr. Meg Smith OAM, Professor Alex Blaczszinsky AM, Dr. Tony Kidman AM etc. and other notable specialists. Other community awareness public meetings e.g. Sydney City Mission, Parramatta Town Hall, Granville Town Hall, Willoughby Town Hall, RSL Clubs etc..
- **A major youth suicide prevention forum "Youth in Discovery"** at Chatswood Municipal Centre.
- **A "Communities That Care" forum** showcasing the spectrum of services associated with mental health in the whole of Northern Sydney from the Bridge to the Hawkesbury. Keynote speaker Professor George Patton from Victoria, Professor David Bennett AO, and the Area Director Mental Health Northern Sydney, Dr. Nick O'Connor.
- **A major two day national conference Moment of Choice 2000** at Sydney Masonic Centre. Speakers from around Australia and the New Zealand Mental Health Commissioner participated.
- **Co-hosted the visit and seminar presentation** at UNSW (attendance 500) of Dr. Martin Seligman president American Psychological Association, author "The Optimistic Child" and world authority to introduce concepts of "learned optimism" as a suicide prevention tool.

Workshops & Training.

- **"Living Works" Applied Suicide Intervention Skills Training (ASIST) and Loss & Grief Workshops**, attended by various professional disciplines (nurses, social workers, psychologists, OT's etc.), private individuals, ambulance officers and others.
- Lectured to Sydney University and Western Sydney University social work, nursing and OT students.

Other activities:

- **Participated with national and state governments in policy-determining forums** including the first "Here for Life" national youth suicide forum, and the national Australian Press Council and government Media Guidelines for Reporting of Suicide conference, many NSW Health Dept. forums. Presented at many national and international conferences.
- **Club SPERANZA** was a major contributor to the book "Leaving Early" by Bronwyn Donaghy initiated by Dr. David Bennett AO a powerful inspection of the lives of people affected by youth suicide and an effective suicide prevention awareness tool. Professor Beverley Raphael AM who wrote the Foreword spoke at the SPERANZA launch of the book.
- **SPERANZA** has been a participant in many magazine and newspaper articles and television interviews and topics. As well it has helped design health service training programs and workshops and debriefing in nursing homes following suicides and attempts,
- **Each year SPERANZA presents Recognition Awards** to people who have made an outstanding contribution in addressing self-harm and SAD. It has been supported by entertainers Normie Rowe and Barry Crocker and sporting giant David Campese. **Club SPERANZA** publishes a quarterly newsletter "The SPERANZA Notebook".
- **Club SPERANZA** is a member of the Consumer Health Forum, the Mental Health Association, Mental Health Co-ordinating Council NSW, Suicide Prevention Australia.
- **The Consumer Health Forum's representative on the NH&MRC Mental Health Research Working Group is a SPERANZA nominee. Four members of SPERANZA** are Board Members NSW Association for Mental Health one of whom was Chairman for ten years and is vice president.
- **Consultation with RANZCP Clinical Practice Guidelines Development Program.**
- **Major participant in the ABC 4 Corners "Duty of Care"** which won the Human Rights Commission Television Award for the year in its presentation of the failure of the mental health services.
- **The development of a youth resilience-building activity suicide prevention program GASS (Go And Surf Social) which includes The Beach Footy Ball Show and "Dancing on Water" with high profile mentors e.g. Layne Beachley as Patron, Kerri Pottharst and other stars. Supported by NSW Health Dept.**

SPERANZA is the Italian word for "hope".

Australian Mental Health Suicide Consumer - Alliance Inc.
PO Box 96 Neutral Bay 2089 41C Yeo St. Neutral Bay. Australia
Registered Charity No. CFN 13281 ABN 62 349 929 262 Donations are tax deductible.

Mental Health Services in NSW
Suicides and attempts: Examples of Reported Cases

These examples are intended to illustrate the defective criteria and protocol for protection of the person, the inability of the service to deal effectively with people at risk without adequate resources, and the failure to provide adequate community services. Obviously these were all in contact with the service,

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. Procedures not implemented.

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. There has been a coronial investigation and police report.

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 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 found 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 nearby grounds.

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 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 and mediated 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. March 2002 Report from mother. ***
Male age 30. Schizophrenia. Hears voices about sixes (the Devil's number) "one of the chosen ones of six", a Chinese person in China is in control of him to kill himself. OD in September 2001. . While still in Intensive Care mother told to take him home "no beds", fortunately a leave bed became available and he was detained for six weeks. A few weeks ago he OD'd on pure heroin. Again difficulty in gaining admission. Short admission again Prince of Wales, released after two days, beds needed. There are no case managers available for him, no cognitive therapy. Close friend suicided few weeks ago left diary message about hallucinations and relationship with Russell Crowe and that she and Russell would jump from the Gap together. She did. This distressed him. He stole neighbour's golf clubs and pawned them for the heroin to deal with the voices. Wanted to suicide because he felt guilty about stealing the golf clubs and could not face the neighbour. He OD'd again on heroin and was admitted again. His condition continues to fluctuate.

Case. S. 2003 Report from mother.
Son, a patient in Hornsby Hospital. Mother returned him from leave in the evening, saw him walk in through the doors. Contacted by police in the early hours of the next morning. Son found dead from heroin OD on a train at Cabramatta.

Case. T. 2003 Report from parents. Official documentation sighted.
Daughter early thirties, patient at Hornsby Hospital. Reported suicidal feelings to psychiatrist and left a letter. Walked out of hospital and body was found 5 weeks later. External review and coronial inquiry recommended major changes in hospital procedures.

Case. U. 2003 Report in newspaper.
Woman hanged herself in Manly Hospital.

Case. V. 2003
Cornelia Rau left Manly Hospital and disappeared. Would appear without follow-up. No reported contact and follow up by community team.

Suicide diversion in action.

A Personal Story. A story to offer hope. 3/11/98

I am Michelle. I'm married, one child, educated and employed, yes I'm one of the "normal" people. I'm writing this to tell people, that even with a well paid job, nice company car etc. etc. all this can be dismissed, written off, ended in a matter of minutes. The decision to end my life was mine ..... all mine.

During the course of my employment as a sales representative, whilst sitting at a set of traffic lights in the middle of the day, I was robbed. A young, clean shaven man, smashed the window, showering me with glass, he then lent into the car with a large knife, put it to my face , I sat in horror as he ripped out the mobile phone from the car kit attached to the dash. *It was all over in 4 or 5 seconds. No one stopped, looked, helped or was it simply that people just don't care anymore?*

I stopped sleeping at night, the nightmares were just about all the same. A man was going to cut my throat. I started to sleep on the floor beside the bed, then under it to hide from him. I became so "crazy" about locking the doors in a car, again and again. I lost confidence in myself because I'm acting so stupid, I'm so tired I can't cope.

This led to me believing I was useless as a wife, mother, employee and person. So I decided to end it.

I set about planning, I will not talk about this as I would hate to influence or upset anyone. During the planning process I justified my action. If anything big or small went in the slightest bit wrong, this proved my point. Anything positive was disregarded.

I did attempt suicide.
Today I'm glad it failed.
This all happened with many factors playing a part in my decision to do this and also to want to be here today.
The straw that broke the camel's back was the robbery.
The branch that stopped me from falling all the way is Club Speranza.

Michelle

Michelle goes on to say,

"Club SPERANZA provided me with:"
Counselling (carefully at critical stages)
Positive affirmations about myself.
A chance for my husband to understand.
A chance for me to explain in depth why and how this became my choice and to help grieving relatives to understand the other side.
The opportunity to provide others, contemplating to attempt this (suicide), with a "real life" role model "not to do it".

A GP's Experience

To Whom It May Concern. 5th March 2002

Working together and networking with different agencies, health professionals and community groups is certainly the way forward in helping people who are depressed and suicidal. Recently, I had a young patient of mine come to see me feeling at the end of her tether. Her father had committed suicide several months earlier, she had resigned from her job as she could not deal with a fairly aggressive boss and now her boy friend of some years had broken off their relationship. She was living in his flat, so now she had nowhere to go except to return to live with her Mum, a long way from her friends. Her Mum and her Aunt are her only relatives and unfortunately, her Mum has an alcohol problem. Prior to all of these difficult stressors in her life, I had already been helping this young girl to learn skills to cope with anxiety and panic disorder.

In talking to my young patient, I became concerned for her safety as she had lost her will to live and could see no future for herself. She said she wanted to die and had decided to take an overdose of paracetamol and anything else she could find in the medicine cupboard. I also felt she was at high risk of suicide because of her father's suicide and her other grief situations. all piling up at once. I felt she needed to be observed at least by the mental health team, if not admitted. I could not just send her home. However, I could not get her local mental health team to see the urgency. The over crowded hospital had no beds and the overcrowded mental health team said if I was really worried, to send her to Accident and Emergency. I felt this was not appropriate for a very depressed, emotionally fragile girl. What could I do? I had other patients waiting to be seen but I was not going to leave my young patient unattended.

I have had the good fortune to work with Tony Humphrey on the Northern Sydney Health Suicide Prevention Committee and through my work with adolescent health, I had heard of Club SPERANZA. A quick phone call to Tony followed. Within 20 minutes, I had a phone call back from the local mental health team, very helpfully organising to see and support my young patient. A friend took her straight over to see them, after which I was able to organise long term counselling for her. I am very pleased to say that she is doing very well and trying to rebuild her life and learning some skills through Cognitive Behaviour Therapy to cope with grief and depression.

Thank you ,Tony and Club SPERANZA!

Carol Kefford (General Practitioner)