3 June, 2005

Main Recommendations

1. The setting up of a standing (on-going) coronial inquiry to examine the pathways to death in all cases of suicide in Australia, whether occurring in hospital or in the community. The inquest should have the power to call witnesses and examine them under oath. The coronial inquiry should be required to focus on the nature of contact over the preceding year between public mental health services and individuals who subsequently suicide, and make regular recommendations on these services. The coronial inquiry should also examine how the regulations of state mental health acts are being applied to see if they are used to cover inadequacies in the provision of inpatient acute beds needed for psychiatric admissions.

2. Additional 24-hour supported and supervised housing accommodation places on the Gold Coast and in other parts of Australia. The Gold Coast attracts a large number of young people from other places who suffer from severe and chronic mental illnesses. These individuals usually lack local family support and need supported accommodation services to compliment community treatment services. Failure to provide supported accommodation blocks patients being discharged from acute inpatient treatment and denies access to care for other patients.

3. Treatment programs in public mental health services for patients suffering from non-psychotic but still severe conditions such as anorexia/bulimia nervosa, personality disorders, anxiety disorders (such as post traumatic stress disorder, obsessive compulsive disorder, generalized anxiety disorder, social anxiety disorder), co morbid psychiatric and substance abuse disorders, and depressive disorders. These treatment services need to be provided across the inpatient and outpatient sectors of the public mental health service and integrated with the private mental health system.

Supporting Documentation

We have discussed Recommendation 1 with Prof Ian Hickie and while he has called for a report on deaths in individuals within 3-months (mainly suicides) and 1-year (other causes of death) of contact with public mental health services, he supports this more pointed approach to a suicide audit. Only with a standing coronial inquiry will all clinicians and administrators in public (and private) mental health services be held to account for the way patients are treated at any clinical contact, not just during inpatient admission. This would profoundly change the current complacent attitudes to the problem from some quarters. The new mental health acts may be used as a 'fig leaf' to cover inadequate resources ("your son doesn't meet criteria for admission") brought about by mental health policies and plans that reduce inpatient and supervised accommodation resources while promising but not delivering community services. These mental health policies/plans are associated with increased suicide rates (see the article - Burgess P et al. Do nations' mental health policies, programs

and legislation influence their suicide rates? Australian and New Zealand Journal of Psychiatry 2004; 38:993-939) compared with national drug policies that usually reduce drug supply and provide more rehabilitation treatment and are associated with lowered suicide rates.

A further thought on risk assessments and the implications for public mental health services. The Gold Coast Institute of Mental Health (www.gcimh.com.au) is calling for a standing coronial inquiry for all suicides, whether within hospital or in the community. Hopefully an ongoing judicial inquiry of this type (with power to call witnesses and examine under oath) will trace the pathway to death of individuals who suicide and examine the links between recent (up to a year) contact with mental health services (public or private) and the suicide. This analysis will throw light on (i) the way individuals are assessed and either admitted or not admitted and followed up when they access mental health services (often via emergency departments), (ii) the discharge decisions about patients (whether too early or not), (iii) the discharge plans for patients, and (iv) the provision of appropriate follow up care and case management in the community. It will be able to explore whether the (new in some states) mental health acts are being used to deny admission to unwell individuals as a cover for lack of resources such as inpatient beds. If this recommendation is adopted all clinicians will need to be careful about decision making, but this is really no more than ethical practice. An ongoing inquiry of this nature will also bring mental health service managers and more senior health officials into judicial oversight in relation to suicides. I anticipate that a standing coronial inquiry into suicides will give clinicians more influence over their work and a greater capacity to make independent decisions with a re-emphasis on individual patient needs over system demands (or inadequacies). The presence of the inquiry and its regular recommendations about mental health services will provoke public mental services to address the current gross inadequacies in inpatient beds, supported accommodation and community services.

The recommendation of the GCIMH is set out below.

The setting up of a standing (on-going) coronial inquiry to examine the pathways to death in all cases of suicide in Australia, whether occurring in hospital or in the community. The inquest should have the power to call witnesses and examine them under oath. The coronial inquiry should be required to focus on the nature of contact over the preceding year between public mental health services and individuals who subsequently suicide, and make regular recommendations on these services.

One of the reasons a judicial review at coronial inquest level is being sought is to make sure no one escapes scrutiny and to particularize the problem so that we are not just talking about statistics but rather individual human beings who have come to grief. It might be that mental health service managers (medical or non medical) and senior health bureaucrats might be the ones most opposed to this proposal.

A proposal of this nature is not intended to be a "witch hunt" nor is it preordained to find blame. It is to review suicides from the particular (rather

than the general) viewpoint and look at any links between access to and experience of treatment and ultimate suicide. One of the reasons a judicial review at coronial inquest level is being sought is to make sure no one escapes scrutiny and to particularize the problem so that we are not just talking about statistics but rather individual human beings who have come to grief. We might agree that a government run inquiry might be reluctant to make adverse findings about government services, but I would hope that the courts in Australia are more independent than that. Unlike you, we believe an inquiry as proposed will be positive, even liberating for those clinicians who now feel encumbered by the demands of managers and the system to ration care - in the future all influences impinging on decisions to treat, not treat, admit, not admit, discharge, not discharge etc will be capable of review in the particular case - a situation that will give considerable influence back to the clinician we expect. It is possible that the most opposition to this idea will come from mental health service managers (medical or non medical) and senior health bureaucrats - we don't know. As you mention, many suicides are coroner's cases so we doubt there will need to be an explosion of staff needed for the proposal which is really a systematic re-emphasis of these inquires to look at suicides that occur in the community and their relation to treatment contact.

As a quality improvement exercise a review of every death would really be a "gold standard". But impractical. The suggestion is to focus resources on one of the most tragic outcomes - suicide - of patients we care for. We agree suicide is a multi-determined behavior, but we expect there is some contribution to the situation due to the availability and quality of clinical services - services we are responsible for or can advocate for. We agree that more should be done for early intervention and child services. In addition, there are many individuals who are now very unwell and for whom early intervention and childhood programs have passed. These individuals need access to inpatient care, supported accommodation and comprehensive community services. The lack of these resources in adequate amounts has been the subject of public comment all around Australia - no state seems immune. Yet progress in remedying this situation is glacially slow and lack of these services may be contributing to suicides. These are some of the reasons for the call by the GCIMH for the inquiry.