

"Mental health failings linked to 42 suicides

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FAILINGS in the mental health system contributed to more than 40 suicide deaths in Victoria over two years.

According to a confidential report, too few acute beds, prolonged waiting periods in emergency departments and a tendency to place patients on community treatment orders rather than admit them to hospital were linked to the death of 42 people under the age of 30 who killed themselves in 2002 and 2003.

An unpublished study by state parliamentary intern Jasmine-Kim Westendorf analyses the findings of coronial investigations into the suicides of 244 people under 30. Almost a fifth of the victims had a history of significant interaction with Victoria's mental health system.

The study says that weaknesses in the system comprised an inadequate response to 42 victims who were suffering a psychiatric crisis. In 11 cases, involving high-risk patients, a lack of mental health beds in acute care led to their discharge. The patients had been assessed as high suicide risks, or had attempted suicide and were being treated for injuries, or had been released shortly after being admitted because of slight improvements in their condition.

"These patients suicided soon after their discharge, indicating the importance of high-risk patients being offered in-patient care until the critical period has passed," Ms Westendorf argues.

Victoria has 21.8 acute beds per 100,000 adults, which is 2.6 beds below the national average. Demand for mental health services has increased sharply during the past five years and Victoria has led the nationwide shift away from institutions to community care in the treatment of mental illness.

According to Ms Westendorf's study, in-patient care is focused on people with psychotic and personality disorders, leaving other high-risk patients untreated.

She recommends a centralised bed-finding agency to improve the allocation of scarce resources so that high-risk patients do not fall through the cracks.

At least six patients who were refused admission or who were discharged after an overnight stay had not been referred to community services for treatment before they took their own life. Eight of the suicides were linked to community treatment orders being issued inappropriately for patients who desperately required a more intensive level of medical intervention and supervision.

In all of these cases, the victims had a history of not taking medication or had been readmitted to hospital involuntarily while they were on community orders after suffering psychotic episodes.

"They were patients whose conditions required intensive treatment such as could not be provided in the community, and whose medical histories should have indicated this to clinical staff."

Ms Westendorf reported that community treatment orders often reflected the system's incapacity to provide resources to people in need, which put them at a greater risk of self-harm.

In three of the suicides investigated by the coroner, it was found that prolonged waiting periods in emergency hospital departments had exacerbated psychiatric distress."

We expect there are many more examples of this unfortunate circumstance around Australia, and not just among the under 30s group. This report adds more weight to the call of the Gold Coast Institute of Mental Health for a standing coronial inquiry into all suicide deaths in the community in Queensland.