Submission To Royal Commission Into Victoria's Mental Health System

By

Graeme Bond

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Introduction

I have found it difficult to write this submission as it causes me to revisit the most painful events in my life. I have procrastinated and delayed until I could no more.

Background

I am the father of a young man who committed suicide in 1993 after an 11 day experience with the mental health system, 8 days being in a hospital that discharged him 3 times in most alarming circumstances. He died 28 hours after his third discharge. I have written elsewhere of this experience and attach an article I wrote for The Age newspaper and which was published in March 2004.

I have since written a number of submissions on Mental Health issues, including the failures of the Coronial System, and will enclose these as they make many of the same points I would make today.

I will largely refer to my previous submissions and comment on progress, lack of progress and sadly, backsliding, that has occurred since.

Coronial System and Its Importance

The Coronial Service may investigate "unexpected, unnatural or violent deaths including homicides and suicides". [1]

In July 2005 I made a submission [2] to the Victorian Law Reform Committee Inquiry Into the Coroner's Act 1985 about perceived deficiencies in the coronial system. I also gave oral evidence to the Committee using a PowerPoint slide set[3] I stand by that submission and evidence, although some improvements have been made.

Coroners over the years have 'investigated' many suicides of mental health patients, former patients and other mentally ill people. Very few have contributed anything that would lead to meaningful systemic improvements and some have been abysmal in their outcomes.

But the Coronial system should play an important role in analysing the ultimate failures of the mental health system, the death by suicide of mentally ill people and in a smaller number of cases, the death of others at the hands of a mentally ill person.

As far as I am aware, Coroners have refused to take a broader look at systemic issues, preferring to look at each case in isolation. This is a major failure. It is a betrayal of the people of Victoria. It is a betrayal of the deceased mentally ill and their traumatised loved ones. It is a betrayal of those who will die in the future but could be saved.

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[1] https://www.coronerscourt.vic.gov.au/inquests-findings/investigation-process/death-investigation-process

[2] https://www.parliament.vic.gov.au/252-lawreform/inquiry-into-the-review-of-the-coroners-act-1985 See Submission 48 including attachments

[3] See transcript of evidence and presentation 22nd August 2005 at previous link

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Mental Health Act

As part of my preparation for this submission, I quickly read what I saw as the most important sections of the Mental Health Act. I was appalled at some of what I read. The Act is, in some respects, worse than ever.

I have also looked back over my submission to the Senate Select Committee on Mental Health in 2005. [4] I was reminded that my submission attracted a 'Response to adverse Comment' from the Director Mental Health, Victorian Department of Human Services [5] something I wear as a badge of honour.

Commitment to Standards

In that submission I wrote:

> In Victoria the Department of Human Services seems to have an endless capacity to churn out strategy papers etc. but fails to commit the resources to give meaningful expression to them.
>
> This is despite the fact that the Mental Health Act states in its objectives:
>
> > **"5. Objectives of the Department**
> > The objectives of the Department under this Act are as follows—
> > (a) to establish, develop, promote, assist and encourage mental health services which—
> > (i) provide standards and conditions of care and treatment for people with a mental disorder which are in all possible respects at least equal to those provided for people suffering from other forms of illness"
>
> **Which part of this does the Department not understand?**
>
> **How can the Department so openly flout their own legislation by so conspicuously and consistently under resourcing Mental Health Services?**

I am now able to announce that the problem has been solved!

The Mental Health Act ***no longer appears to contain any commitment to***: "provide standards and conditions of care and treatment for people with a mental disorder which are in all possible respects at least equal to those provided for people suffering from other forms of illness"

[4] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/submissions/sublist Submission 484

[5] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/adverse_comment/index

Least Restrictive Environment

The Mental Health Act used to include in its objectives: [6]

> "people with a mental disorder are given the best possible care and treatment appropriate to their needs in the least possible restrictive environment and least possible intrusive manner ***consistent with the effective giving of that care and treatment.***" [my emphasis]

The qualification I have emphasised was widely ignored and I have previously draw attention it.

But again, the problem this posed has been solved in the new 2014 Act by substituting this provision:

> "to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity". [7]

> "persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred. [8]

The concern for giving effective care and treatment has been removed.

It is rather curious that there is reference above to 'voluntary assessment and treatment being preferred' since the Mental Health Act now only applies to involuntary patients. Which brings me to another point.

Abolition of Voluntary Patients

In what I regard as one of the most bizarre actions of the Kennett Govt, it removed Voluntary Patients from the Mental Health Act. Why? How and where are such patients to receive Mental Health treatment?

It also provides a perfect excuse to prematurely discharge a patient still in need of treatment or to refuse a patient who recognises their need for treatment and seeks it voluntarily! All they have to do is say they accept treatment voluntarily and they no longer meet the criteria to be treated as an involuntary patient under the only legislation specific to Mental Health patients, the Mental Health Act.

Right to Treatment

The Mental Health Act rightly includes concerns about rights of patients. This is commendable.

But the glaring omission is an 'Right to Treatment'. Why? This should be the paramount right that trumps all others.

Crisis and Assessment Teams

I have sat in a Coronial Inquest and heard the sworn evidence of a CAT member that Crisis and Assessment Teams will not attend a crisis! [9] Yes, that's right, the teams established to attend a crisis will not do so.

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[6] Mental Health Act 1986 S4 (2) (a)
[7] Mental Health Act 2014 S10 (b)
[8] Ibid S11(a)
[9] Coroners Case No. 201/02 2005

When called their response is 'call an ambulance' or 'call the police'. A patient in a psychotic state will frequently refuse to go with ambulance officers and so the ambulance officers will advise calling the police.

Involvement of Police

I regard it as an appalling situation that Police have become the front line of the Mental Health System.

Their training in Mental Health issues is of necessity brief. They are equipped to use lethal force and are often seen as threatening by mentally ill people who may respond with aggressive behaviour that is met with force. This has resulted in many instances in fatal consequences.

Police Divvy Vans, the Ambulances for the Mentally Ill

When mentally ill people refuse to accompany Ambulance Officers, even if they offer no physical resistance, Police are called and usually end up taking the patient to hospital in the back of a police divvy van. These people are not criminals, they are patients.

Mainstreaming

Another bizarre idea is the concept that Mentally Ill patients should be admitted through Accident and Emergency as if they were presenting with a physical illness.

Dr Peter Archer of Maroondah Hospital documented the consequences at his A&E Department, including a patient producing a large knife, another patient stealing an ambulance, disturbed patients in the presence of injured people and patients being sent away and committing suicide or in one case killing a partner. [10]

It was fortunate indeed that Dr Archers letter to the Minister did not simply disappear into DHS to be dutifully filed and ignored. Some enterprising person faxed it in to the Jon Faine program on ABC 774 and it became public knowledge. But of course the Department could relax, secure in the knowledge that after some initial outrage the fuss dies down and nothing need change.

In my experience with a mentally ill person, they may wait from when they are taken to A&E in the evening until around the middle of the following day before being assessed. They may then be not admitted or, conveniently, they may have left before the person designated to do the assessment eventually arrives.

This sort of delay is unconscionable and does not happen with any other type of illness.

Risk Management

I have considerable experience of Risk Management in industry where recognised standards have been mandated to be followed. These include AS/NZS 4360 and ISO 31000.

I have never seen any reference to any recognised standard in any documents from DHS.

[10] Archer, Dr P., Letter to Minister for Health, 15 Feb 2002 (Copy accompanies my submission to the Senate Select Committee on Mental Health op. cit.

What I did see was a document produced by the Chief Psychiatrist back around 1992/3 requiring a patient risk summary to be at the font of every mental health patients medical history.

Needless to say, there was no such document in my son's medical history. And of course the Psychiatry Department and its staff at the hospital at which my son was supposedly treated appeared to have no knowledge of any such requirement.

At my son's inquest, the Registrar supposedly treating him was asked about patient risk assessment and he was at a loss for words when asked such questions as was a prior suicide attempt a primary indication of ongoing risk? The Coroner helpfully intervened and assured us all that she was sure assessment of risk was a much more subtle process than could be accomplished with any sort of check list! Utterly disgraceful conduct.

The generic standard at the time was AS/NZS 4360 which had a simple approach applicable to any industry or circumstances.

1. Look at the context of any risk.
2. Identify any risks.
3. Rank the risks in order of seriousness.
4. Take steps to mitigate any high risk.

To rank risks, each risk is examined in two dimensions, the likelihood of it occurring and the consequences if it does. Each risk is then given a ranking according to a simple matrix reproduced below.

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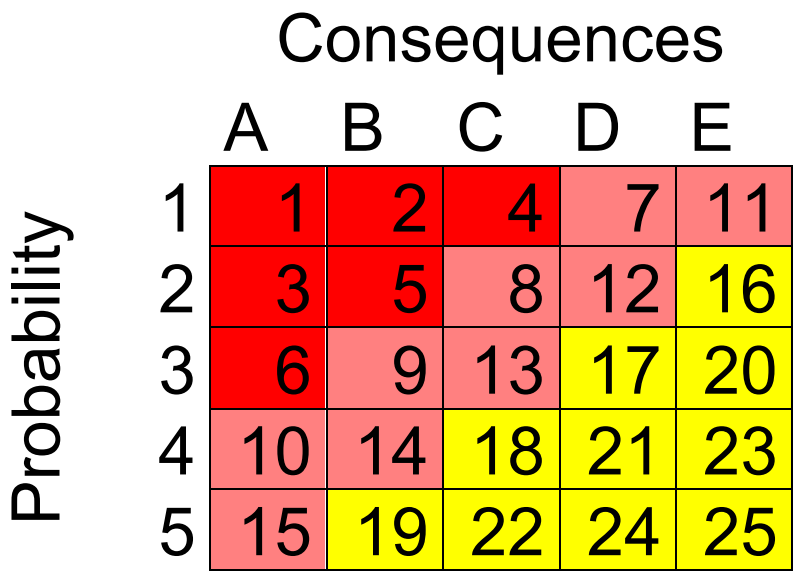

HIGH = 1 - 6
Medium = 7 - 15
LOW = 16 - 25

Key

A	Will stop the project increase the costs to double or more.
B	Will cause the project to run over time and effect business operations, cost up by more than 1/2 the budget.
C	Will result in the project over run no effect on operations, with a cost over run
D	Will result in a cost over run.
E	Will result in conflict between the client and supplier.
1	This event happens all the time.
2	I have experienced this before in other projects
3	I have heard of this happening.
4	It could occur given the right events.
5	It is unlikely to happen.

This example is from managing a project, but all that needs to be changed are the descriptions in the Key for it to be applicable to any circumstances.

In a clinical setting, a risk with consequences as dire as patient death or incapacity does not need a very high likelihood to be rated as a highly ranked risk requiring action to positively address it.

A risk with consequences that are trivial such as minor social embarrassment, even if a near certainty ranks relatively low and might even be ignored.

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Hospital Protocols

After the death of my son, the Hospital concerned conducted an internal review [whitewash?]. One of the issues looked at was an evening when he absconded and was eventually returned to the hospital by police after having been beaten and robbed in the street. He was slightly intoxicated and very distressed. When staff couldn't calm him, after refusing an offer of assistance from one of his friends, they simply allowed him to leave the hospital at about 3:00am, intoxicate, with unknown injuries from a beating and a recent near fatal suicide attempt.

The hospital had a protocol dealing with when a disturbed patient attempts to leave the hospital. The staff, from the head of the Department down, appeared to have no knowledge of it. It provided for such a patient to be followed. What happened was that a staff member simply went to a computer terminal and discharged him!

From all that I have seen and heard from others, there is no culture in the mental health system of requiring staff to be familiar with protocols and to follow them. In fact in my son's case, it seems staff were not even aware of the existence of their own protocols.

This culture extends well beyond hospitals and permeates the Victorian Public Service, particularly DHS.

I got a clue to it when I read an Auditor General's report on an IT Project where the two main decision makers were a couple of characters named 'Unknown' and 'No-one'. In subsequent dealings with a number of VPS Departments I have encountered other such characters including 'Someone Else', and 'Not Me'. There is not a culture of taking responsibility or accountability for much at all.

Enforcement of Legislation, Contracts, Protocols etc.

I have found that there seems to be a culture of Management not having any mechanisms in place to ensure that instructions are followed, even when they have the force of law, or are a commercial contract.

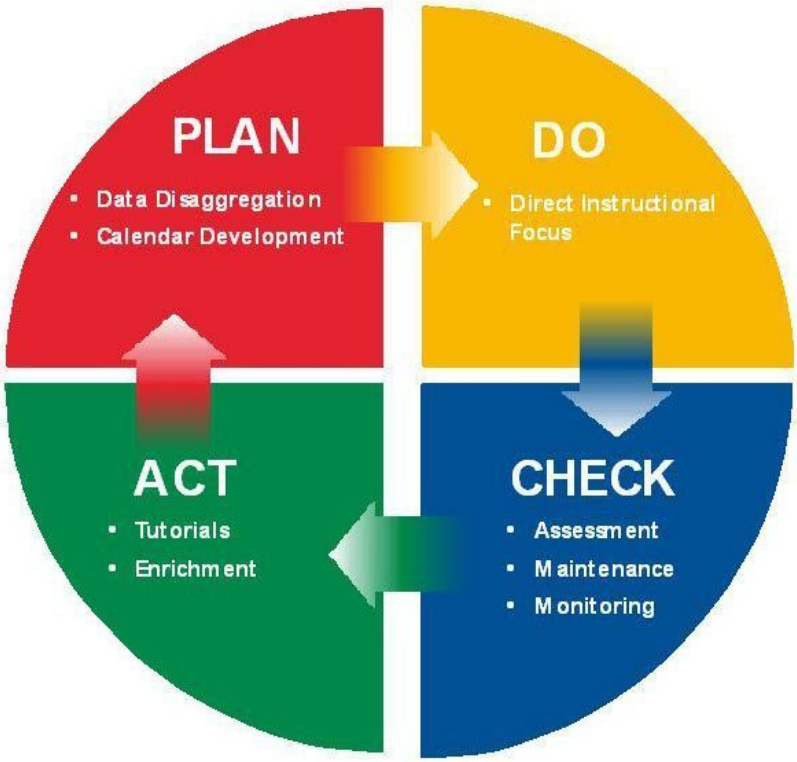
This was evident with the Chief Psychiatrists mandating a Patient Risk Summary at the front of each Patient History. It just didn't happen and there was no follow-up mechanism to make sure it did and that chap 'No-One' was apparently responsible. Or was it 'Someone Else'?

Quality Issues

The fact that some of the defects I have pointed to have persisted for so long is indicative of the absence of any process of 'Continuous Improvement' as is widely used in industry. This ties back into enforcement of protocols etc.

"A continual improvement process, also often called a continuous improvement process is an ongoing effort to improve products, services, Continual improvement process These efforts can seek "incremental" improvement over time or "breakthrough" improvement all at once."

A simple illustration of this appears below.



Work of the Auditor General

I have earlier disparaged the work of the Coroners in investigating the failings of the Mental Health System.

One seemingly unlikely organisation that has done some good work is the Victorian Auditor General's Office [VAGO] which takes a systemic approach.

They first came to my attention when I read their October 2002 report "*Mental Health Services for People in Crisis*. [11] As I wrote in an article in The Age [12]

> The statistics in the report are stark: 0 per cent of discharge plans met all the required standards; only 4 per cent of patient files met audit standards; 0 per cent of individual service plans met all required standards; in only 6 per cent of cases was there evidence of carer collaboration in "case closures"; carer psycho-education (educating carers about the condition of patients) was absent in 98 per cent of files reviewed. In short, the report disclosed a massive problem concerning quality.

Yes that was 2002 and easily dismissed as being all in the past. Except for one thing, VAGO have produced a much more recent report 'Access To Mental Health Services' [13] showing not much has changed.

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[11] https://www.audit.vic.gov.au/report/mental-health-services-people-crisis

[12] https://www.theage.com.au/national/critical-condition-20040317-gdxi9g.html

[13] https://www.audit.vic.gov.au/report/access-mental-health-services

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Effects on Family

The effects of my son's death on my family have been profound and long lasting.

[redacted] developed a bi-polar disorder which has seen [redacted] hospitalised numerous times. This is where I draw much of my more recent knowledge and experience of the system. [redacted] has made several suicide attempts and, while [redacted] illness was wrongly diagnosed as depression, was subjected to a number of ECT treatments.

Since [redacted] diagnosis has been sorted out [redacted] has fared much better and now copes well most of the time. I had repeatedly described the manic episodes to staff at the Psychiatric Inpatient facility, but for years was ignored as they stuck doggedly to their incorrect diagnosis, adding further to her plight.

[redacted] has had to abandon plans to return to her profession.

[redacted]

I was alerted by customers that I was not coping well and after seeking help was diagnosed as having PTSD for which I continue to suffer and take medication.

I was unable to work properly and sought to claim on a 'Life and Livelihood' Insurance Policy but was initially told it did not cover my situation, apparently because I was still able bodied. Eventually they decided years later that they would cover me but imposed other onerous conditions relating to production of proof of earnings that I was unable to meet their demands.

My business was targeted by credit card scamsters, aided and abetted by the [redacted], and I could no longer conduct the business due to the stress. The Bank held me liable for the credit card scam. I had to re-mortgage my house to pay them and stop their harassment. I should add that when my son died the bank was quick to express their sympathies and then suggest that I put all my accounts with them. My mortgage had been with another bank and it was my taking their advice that made it possible for them to subsequently threaten my home.

I survived for several years with financial assistance from my parents before being able to get a job.

The Health Services Commissioner told me to wait until the Coroner had finished the inquest and they would then deal with my complaint. When the inquest finished, they then said that since it had been examined by the Coroner, they were prevented from accepting my complaint! Sheer duplicity.

Despite some misgivings, I took a contract position at a building close to where my son had been in hospital. Then to make matters worse, I was seated at the only window on the floor with a view of that hospital, putting me constantly ill at ease. In breach of my contract I was dismissed after approximately 2 weeks with a manager commenting I had not seemed enthusiastic. No-one ever asked if anything was wrong and I was well ahead of schedule in my project.

I have now effectively been forced out of the workforce. Despite literally thousands of applications over the past 10 years I have not been able to get a job, contract or permanent. My references and recommendations speak for themselves and I am exceptionally highly qualified with 4 tertiary qualifications including a Master of Information Systems and an MBA[Hons].

I am estranged from my [redacted] who developed increasing anger over [redacted] death and exhibited some suicidal tendencies. I have not seen [redacted] for several years.

[redacted] resorted to substance abuse while in High School after [redacted] death and has had mental health problems. [redacted] has surmounted these and is making a success of [redacted] life.

Will Anything Change as a Result of this Royal Commission?

Well has much changed as a result of previous inquiries and reports?

Some things have actually got worse, in my opinion, for example the legislation.

But the Premier has committed to implementing all of your recommendations. I take him at his word, so it is up to you, the Commissioners to get it right. I am available to appear before the Commission or otherwise discuss any of the matters in this submission and beyond.

2019 Submission - Royal Commission into Victoria's Mental Health System

Submission Questionnaire
SUB.0002.0029.0394

Name
Mr Graeme Bond

What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?
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What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
-

What is already working well and what can be done better to prevent suicide?
"Not aware of anything working well, but I suppose there are some things somewhere. Avoid premature discharge of people with a suicidal risk. Utilise best practice risk assessment and management for patients at any risk. The rights of patients under the Mental Health Act notably don't include any right to treatment."

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
"I can only speak from my experience, but workplace bullying has an adverse effect. From observation, peer bullying of teenagers is also a factor."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
-

What are the needs of family members and carers and what can be done better to support them?
"How about keeping them properly informed, particularly when they are expected to care for a patient post discharge?"

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
-

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
-

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
We could start with a decent Mental Health Act. The present Act is worse than the previous Act in some respects. De-instutionalisation has been a failure in many respects. Why do we have so many mentally ill people living on the streets or in prison? At the very least such people should be housed in accomodation with nursing support to ensure they take their medication and to look after their physical health and hygiene.

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
How can this be answered without knowledge of the changes to be made?

Is there anything else you would like to share with the Royal Commission?
The Coronial system does not handle cases involving the death by suicide of mentally ill people very well. It should take a systemic look at multiple cases and seek to make recommendations to improve the system that has failed.