Submission by [redacted] to the Royal Commission into Victoria's Mental Health System.

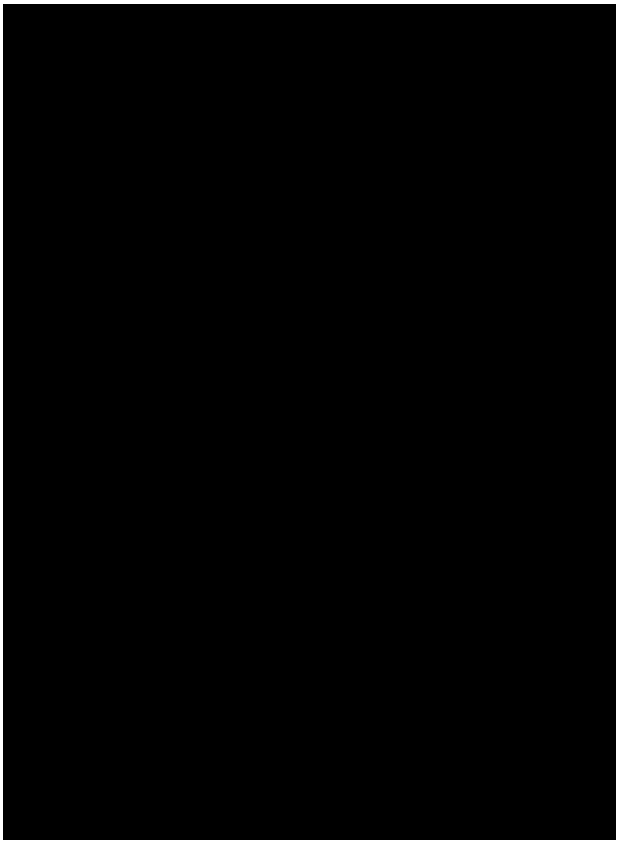
Dear Commissioner,

I am making this submission to the Royal Commission into Victoria's Mental Health System based on my personal experience as a father who has lost a son to suicide due to a mental illness. My focus is on what I see as:

1. A lack of consideration of the risk of suicide faced by some sufferers of mental illnesses by mental health professionals.
2. A lack of understanding of their vulnerabilities by mental health professionals.
3. A lack of ability and/or willingness from the authorities to recognise these failures and take adequate actions to improve the Mental Health System in order to improve suicide prevention.

I hope that the sharing of my story will help to change the approaches, attitudes, beliefs and practices of mental health professionals and the Mental Health System towards sufferers of mental illnesses at risk of suicide.

My son [redacted]



My eldest son [redacted] took his own life on the [redacted]. He did this because he was not in a right state of mind at the time. He was struggling with depression and also, I believe, with the side-effects of his new antidepressant medication. I know that [redacted] wanted to live, to experience life, to achieve goals and to stay positive, in spite of the struggles and disappointments that he had to deal with since 2012.

Things were improving for him at the beginning of 2017. He got his first full time permanent job in February and started a romantic relationship the following month. At the beginning of April, he went skydiving and took a one year gym membership in May. He was watching what he was eating and told his mother a few months before his death, that he wanted to get married and have children one day.

[redacted] was really a wonderful young man. He was gentle, generous, kind, affectionate, compassionate, respectful of others, easy going, humble and much, much more. He was the perfect son, brother and friend. Yet at just 27 years of age, he died in an awful and violent manner.

I have absolutely no doubt that [redacted] death was preventable. I believe he did not get the adequate professional care that he desperately needed to keep him safe.

The events leading to [redacted] death.

In early April 2012, [redacted] had a "breakdown". He began to exhibit suicidal ideation and was making plans to take his own life. After a few visits to our GP, [redacted] eventually asked to be admitted to hospital on the [redacted] as he was feeling unsafe.

There were a lot of administrative difficulties to get [redacted] admitted to a hospital, as he did not have a referral from a psychiatrist. With help from our GP and a psychologist, contact was made with a specialist and [redacted] was admitted to a private hospital and a consultant psychiatrist was allocated to his case. [redacted] was diagnosed with severe depression and anxiety and spent some 5 weeks in hospital.

He was an in-patient until [redacted], after which he continued to receive out-patient therapy. The consultant psychiatrist became his regular psychiatrist.

By mid-2013 [redacted] complained of unwanted side effects from his antidepressant medication. The medication was changed but his depression returned and his feeling of unworthiness, of having no future and suicidal thoughts and plans returned. Again, he asked to be admitted to hospital because he felt unsafe.

Throughout 2013, [redacted] had three hospital stays of a few weeks on each occasion. Finally, towards the end of 2013, the right antidepressant medication and dosage was worked out and [redacted] was able to have a "normal" life with the help of medication. He was seeing his psychiatrist regularly and tried to stay positive and live his life as best he could.

He was finding it difficult to get a job and see a positive future. But then at the end of 2016, [redacted] got a temporary job. He was later offered a full time permanent position in February 2017 by the same employer. [redacted] was over the moon following this offer and believed that things were finally changing for the better.

On the [redacted], my wife and I went on a holiday to Europe and as far as we were concerned, [redacted] was fine when we left. We called [redacted] every second or third day. He mentioned having some difficulties at work, following the implementation of a new software, that he was concerned that his job could be abolished soon and that he was having trouble sleeping.

Upon our return on the [redacted], he seemed a bit agitated and we thought that it was due to frustrations with the new software at work, which was causing processing delays. He was also not sleeping properly.

His job involved spending long hours in front of a computer screen. This was one of a number of changes in [redacted] life which highlighted the unwanted side effects of his medication. He requested for a change of his antidepressant medication in mid-June 2017.

On [redacted], [redacted] told us that he was meeting his best friend in the city and that he was going to see a movie. That night [redacted] attempted suicide by taking an overdose [redacted]. This suicide attempt was a complete shock to us.

[redacted] rang an ambulance himself and was taken to a public hospital in Melbourne. He told staff at that hospital that he was seeing a psychiatrist on a regular basis and they recommended his transfer to the private hospital where he had stayed in the past and at which his psychiatrist was a consultant.

The next day my wife and I picked [redacted] up from the public hospital. He had a few hours at home with us before he was admitted to the private hospital at 5 pm on the [redacted] Later that evening he had a meeting with his psychiatrist, at which my wife and I were present.

[redacted] told his psychiatrist that he was suffering from insomnia since the medication change. The psychiatrist said that the new medication was the one with the least side effects on the market and it would be worth to continue taking it for a bit longer. [redacted] expressed some concerns about the possibility of losing his job if he were to stay in hospital. At the end of that meeting, the psychiatrist said that staying in hospital would bring [redacted] down further. [redacted] was discharged from the hospital after that meeting and was given an appointment to see his psychiatrist on the [redacted]

At that appointment, my wife told the psychiatrist that [redacted] had told her earlier that he was having thoughts of walking in front of a train. The psychiatrist did not seem concerned by this information and replied “there is a difference between having a thought and passing to the act”. He did not question [redacted] about these thoughts or how he was coping with them.

[redacted] again mentioned that he was still having trouble sleeping. He was prescribed sleeping tablets and the psychiatrist gave [redacted] a different pack of antidepressants and asked him to stop taking the current one and start taking the new one. He gave [redacted] an appointment to see him on the [redacted]

On the [redacted] took his own life by getting in the path of a train.

My concerns regarding the actions of [redacted] psychiatrist following [redacted] suicide attempt.

After [redacted] death, I started to go through the responses and decisions of [redacted] psychiatrist at the meeting of the [redacted] appointment of the [redacted]. It became obvious to me that [redacted] death was preventable. I feel his psychiatrist did not recognise the gravity of his condition or given [redacted] safety the priority it really deserved at either of these two meetings.

The psychiatrist was aware of the recent change of antidepressant medication, the difficulties [redacted] was having at work, the recent breakup with his girlfriend, his insomnia and the suicide attempt by an overdose. Yet, he did not adequately appreciate the gravity of [redacted] condition and did not consider the possibility that [redacted] could make another suicide attempt after leaving hospital.

When [redacted] saw his psychiatrist on the [redacted], there had been no change to [redacted] stressors and no therapeutic benefit from his antidepressant medication. The psychiatrist did not seem to give [redacted] safety any consideration. He did not ask [redacted] about his suicidal thoughts or how he was coping with them. He did not provide any advice or warning to possible adverse side-effects from the new medication or about safety. He did not make any mention of a need to re-evaluate the need for [redacted] to be in hospital following the new information on suicidal thoughts or the change again to a new antidepressant medication.

I wish he had given serious consideration to [redacted] safety following the suicide attempt and adopted a cautious approach to ensure his safety.

The psychiatrist's responses to the Coroner

In the Coroner's report into [redacted] death, the psychiatrist provided the following explanations for his decisions and actions following [redacted] suicide attempt.

- He properly assessed [redacted] on the [redacted] by observing that he was "in quite good spirits".
    - *I question whether "in quite good spirits" is a medical measure of [redacted] mental state.*
- [redacted] had expressed a fear of losing his job if he were to stay in hospital and he felt that his patient's rights and wish to be treated at home had to be respected.
- Loss of job would adversely impact [redacted] mental health.
    - *The psychiatrist seemed to give more weight to [redacted] concerns about the possibility of losing his job if he were to be absent from work than the worst-case scenario of losing his life.*
    - *Furthermore, he did not take into account the fact that [redacted] job had become a stressor and contributed to his overdose attempt (mentioned in the Coroner's report).*

- He had a "safety" plan in place, which basically was that if [redacted] felt unsafe or if his parents had any concerns, [redacted] or his parents could contact him by telephone at any time.
    - *The psychiatrist's "safety plan" was not communicated to us as an actual plan. It would seem to put the onus for activating it into [redacted] and our hands, yet we were given no explanation of when or what should trigger its activation.*
    - *The psychiatrist's decision to discharge [redacted] from hospital on the [redacted] and "relaxed" attitude to [redacted] suicidal thoughts on the [redacted], meant we were ill prepared to recognise concerning signs from [redacted]*
    - [redacted] *was not in a state of mind to make a decision about what was best for him.*
- [redacted] had given "assurances" for his safety at the meeting on the [redacted].
    - *I question how appropriate it is that an experienced psychiatrist should rely on assurances of safety from a patient suffering from severe depression and who had made a suicide attempt some 36 hours earlier. Furthermore, [redacted] condition together with possible side effect of his new medication, would have made him subject to impulsive and irrational thoughts and behaviours.*
- [redacted] did not act on his thoughts in the past.
    - *Yet he had taken an overdose [redacted].*
- [redacted] was not at imminent risk when he saw him on the [redacted]
    - *Three days later [redacted] took his own life.*

Not one single error or failure from the psychiatrist was found by the Coroners Court and there was apparently nothing that could have been done differently by the psychiatrist, in spite of the warning signs available to him, the opportunities for him to take decisive action and the tragic outcome to [redacted]. I find this very difficult to understand and accept.

It is possible that the lack of adverse findings and recommendations by the Coroners Court in this case, is due in part to its legal "limitations".

Since [redacted] death, I have been asking myself almost every day, how did an experienced psychiatrist fail to recognise the many indicators pointing to the gravity of [redacted] condition and fail to consider the possibility of [redacted] making another attempt on his life within the coming days or weeks.

I believe that [redacted] psychiatrist got his treatment priority and strategy completely wrong and I have no doubt that his errors and failures contributed to [redacted] death.

My thoughts for the Royal Commission

Below are my thoughts and input to this Royal Commission, based on my personal experience as a father who lost a son to suicide due to depression.

1. Mental Health Professionals need to focus more on the risks of suicide and safety.

The real risks of suicide associated with some mental illnesses, such as severe depression, need to be given better consideration by mental health professionals and they should strive to ensure the safety of their patients who may be at risk of suicide. They should act with great care, making no assumptions and taking no risks.

Mental health professionals and the Mental Health System need to view and react to suicide attempts with much greater concern and prudence and think of the worst-case scenario for the individual. It is better for a health professional to be over cautious and save the life of a patient than to be relaxed about the patient's condition and risk the individual's life. While no patient wants to be in hospital and hospital may bring some patients down, health professionals need to be realistic and prudent about the vulnerability of and risks faced by the sufferer and the necessity of hospitalisation for some of the mentally ill. Striving to prevent the sufferer from taking his/her own life should be the main aim of the health professional.

In my opinion, in order to minimise the risk of further suicide attempts for those who have made one, those individuals should be kept under professional observation in a hospital or other specialised institution for a least 72 hours and be evaluated by a team of professionals (psychiatrist, psychologist and social worker), during their stay and discharged only when all members of that team agree that the sufferer is no longer at risk of making another attempt on his/her life.

2. The need for an Independent Mental Health Authority.

For lessons to be learned from serious errors and failures committed by mental health professionals and hospitals, these must first be recognised. As it is unlikely that professionals and hospitals will openly admit to any error or failure from their part, there need to be a truly independent authority that seriously looks into them, without restrictions or limitations.

In order to achieve real progress regarding mental illnesses and suicide prevention, I believe that a Mental Health Authority has to be established. This new Authority needs to have the will and power to recognise errors and failures, to recommend changes and ensure that they are implemented.

This authority will look into and ensure adherence to best practice standards in matters of treatment, care and support (psychiatric, psychologic, social and other) for those suffering from major mental illnesses and those who have been struggling with a mental illness over a long period. It will also receive and investigate concerns and complaints about inappropriate or inadequate treatments provided to the mentally ill by mental health professionals and investigate suicide caused or contributed by the negligence or incompetence of health professionals.

Furthermore, this authority should also have the ability to hold those who have committed serious mistakes accountable for their actions and take meaningful action against them. Only then, can progress be made regarding the professional attitudes and approaches to and treatments of sufferers at risk of suicide, and can senseless deaths be prevented.

3. The importance of Education.

I believe that if my wife and I were given information or advice about the suicide risks faced by [redacted] at some point by hospital or psychiatrist, the suicide risk factor would have been on our minds and this could have saved him. In fact, if I was given that kind of information before [redacted] left the private hospital on the [redacted], I strongly believe I would have questioned why he was not being kept in hospital.

Education about the risks and safety for family and caregivers could assist in preventing deaths. Unfortunately, the Mental Health System does not seem to value the importance of education and family support. New approaches and practices need to be considered by the Mental Health System, because without a willingness to change, then opportunities for corrections and improvements will be missed.

Every life matters and all efforts need to be made to prevent the mentally ill from ending their lives.

My son [redacted] did not deserve to die at 27 years old and in the horrible way that he did; no one does. In the end, he did not get the adequate professional care that he desperately needed to keep him safe.

I hope that the story of my son [redacted] and my experience of and thoughts on what went wrong and what could have been done better and/or differently will contribute in one way or another to much needed changes to our Mental Health System, to ensure that those who are at risks of suicide due to a mental illness receive all the help they need, that their vulnerabilities and struggles are properly recognised and dealt with, that greater focus is placed on ensuring their safety and that they are not let down by the professionals and the System who are meant to help and keep them alive.

There is no such thing as suicide for no reason and every life should matter.

Thank you.

[redacted]

3/7/2019