

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 19 September 2005

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Ms I. Collins, director, Victorian Mental Illness Awareness Council.

The CHAIR — We welcome Isabell Collins who is the director of the Victorian Mental Illness Awareness Council. Isabell, you have appeared before us before so you understand that these proceedings are being recorded by Hansard, they are subject to parliamentary privilege and they will be on the public record?

Ms COLLINS — Yes.

The CHAIR — Please take us through your submission for 10 minutes and then we will ask some questions.

Ms COLLINS — I guess it is probably important to say that part of our role at the Victorian Mental Illness Awareness Council is to advocate for people who have a mental illness or emotional problems. Out of that role I have advocated for a number of carers whose adult child has suicided. Some people might ask why we advocate for carers. My argument is that any parent who has lost their adult child or child to suicide clearly becomes a consumer because I have yet to meet one who has not been extremely depressed as a consequence of that suicide. In advocating for people — I have a background in nursing, although I have not nursed for sometime — part of the role is to look at the medical records to see what standard of treatment and care the individual received and to then advise the parents or their lawyers on my opinion and to make a generalised statement.

I have attended inquests and I have been disturbed by the lack of rigour and the lack of recognition of the importance of assessments, in particular in in-patient facilities. Most of the people who come into in-patient facilities now meet all of the criteria of the Mental Health Act as involuntary patients. In a nutshell this means that they are very unwell and at that point in time are a risk to themselves or to others — in other words, most of them are suicidal. I have said many times that the level of risk assessment that is conducted borders on negligence — for example, if you have somebody who is feeling suicidal, it is the feeling side of the illness that is going to lead the person to take their life. Again, you can pick up any medical file in this state and 99.9 per cent of the time you will not find a single sentence in the medical file that outlines how the person is feeling. Usually people are asked whether they are suicidal. If they say no, that is pretty much the end of it. If they say yes, they will be asked if they have got any plans. If they say no, they may be put on 15-minute sightings, or they may not. If they say they do have a plan, they will more than likely go into the high-dependency unit or seclusion room, which most patients will tell you they find extremely traumatic. So it does not relieve the feeling side of a person's illness; by all accounts it will make it much worse.

Another example is that a lot of people will come into hospital because they are psychotic, or because they have a diagnosis of schizophrenia. You will find no exploration of that — for example, the doctor's role is to examine and assess the person, order the medication, usually anti-psychotics. The nurse's role in making an independent assessment, I need to stress, has been a requirement of nursing practice ever since I have been nursing — keeping in mind that I have not nursed for a while — in the 1960s. It is well documented, it is a requirement and continues to this day to be a requirement for registration in practice that nurses undertake individual assessments of their patients. So the role of the nurse is to dispense medication but also to do an assessment of the patient about how those voices might be impacting on somebody. For argument's sake, if somebody has feelings that their fluid is poisoned or somebody is going to try and kill them, whilst that is not real from the point of the view that it is psychotic, the feeling side of it for the patient is very real. The nurse's role ought to be to sit down with that patient, make an assessment about what voices they might be hearing, how they can relieve that emotional distress that that psychosis might be eliciting for the patient, and work out strategies so that that can be relieved.

You will not find that, unfortunately, and I fail to understand why in most instances you will not find any assessment to make a generalised statement. What appears to be to be happening is that the psychiatric registrar does an assessment and the care plan is written from that assessment; and it is usually to do with medical aspects. For argument's sake, if you have somebody who is suicidal you will find an alert in the file and the strategy is to place them in seclusion. To give a prime example, I know a man who is extremely depressed now and I worry every time I see him about whether he is going to survive his depression. He came into hospital having never been in hospital before. He was a computer programmer. He is Muslim. After September 11 he experienced extreme prejudice at work and horrible emails from his colleagues. He eventually became quite depressed and lost his job. As a consequence of his depression he went to a hospital, expressed concern about that and was admitted to an in-patient facility.

The care plan said he needed a variety of therapeutic modalities. If you look through the file there is nothing there. Nothing happened for this man at all. He eventually said he was going to go home because they were not doing anything for him, apart from giving him medication. Nobody told him he could not go home. He went to the nurses' station to say goodbye and he was grabbed by the nurses, held down, stripped naked, injected and placed in a seclusion room. He woke up with nothing more than his underpants on, contrary to the Mental Health Act which is very clear that a person must be provided with appropriate bedding and clothing. He met the criteria for involuntary detention at that point in time, but some hours later all of a sudden this man had completely recovered and was discharged from hospital with no need for follow up. This man was a political refugee who had been held in Iran and tortured. As a consequence of this treatment he has been terribly depressed ever since. If this man eventually suicides I will stake my life on it that it will not be picked up by the coroner.

There is also the example I have given in here about the young boy who had three admissions to hospital. Having read his complete set of files — three files from three different hospitals — I know there is not a single sentence in them about sitting down with this young man and trying to work out why he is depressed, or why he is feeling the way he is. Is it to do with his sexuality? How much did that nurse's prejudice impact on how he was feeling? His partner gave evidence to the coroner about the incredible impact that had on him and the coroner dismissed it. Each side seems to call in medical experts. Doctors are not experts on nursing. They are independent professions to each other. They have interdependent responsibilities, but they are completely and utterly independent professions. Nurses are not doing their job in mental health and that is simply not being picked up.

After this particular case I went and saw the coroner to express concern about the lack of rigour. He indicated to me that I was talking about psychological autopsies and that the government does not provide funding for psychological autopsies. It would seem to me that may enhance one's ability to work out what might lead people to take their lives, but it does not negate the fact that in any inquest in relation to suicides they look at medical standards and whether they have been complied with. They should be looking at nursing standards as well. Given that nurses have more contact with the patient than any other professional, in particular at in-patient facilities — but I daresay in the community sector as well — we are ignoring this important component of treatment and care.

I am yet to meet a parent who has not been far more depressed after a coroner's inquest than they were beforehand. Most have said to me that they want to go through the inquest process because they do not want their son or daughter's death to be a waste of time. I now warn parents that if they think they are going to get some peace out of the coroner's inquest, they are very wrong — they will not. That is about lack of rigour. It would seem to me that we have a system where the health organisation's role is to try to protect the hospital. We will always have that conflict — for example, the last inquest I went to was about a young man who was an involuntary patient. A group of involuntary patients had been taken for a walk outside the hospital. He went to the nurse half an hour after everybody had left and asked if he could go for a walk. They let him go for a walk and he walked straight to a railway line and jumped in front of a train. The lawyer for the hospital said, in front of the mother, so-and-so killed himself because he had rung his mother 10 times that day to ask if she would take him home and she said no. When you are that desperate to take blame away from the hospital, you really have to question the way it is being done. There was no account of the fact that they let an involuntary patient go down the street on his own without an escort — that did not seem to be an issue for the hospital, if that makes sense.

I do not really know whether it is possible to have a system similar to what goes on when you go before the health complaints commission for conciliation so any new evidence that comes out at conciliation cannot be used if somebody is going to take civil action after that, whether there is some of process that we can have a situation where people are not trying to protect an organisation or clinicians but rather allows people to sit down as a group and try to work out ways to identify what could have been done differently in order to prevent future suicides. What I do know is 21 people per year suicide within five weeks of discharge from hospital and an average of 180 adults within the adult mental health system are taking their lives. That is an awful lot of people. It seems to me that we are not getting to the root cause. One of the root causes or contributing factors is the way we currently deliver care and treatment. It seems to me that it is more about containment than taking care of the individual and providing empathy and support.

The CHAIR — Thank you for that. Essentially the point you are making in your submission is that in many instances where these deaths occur the accepted standards of practice have not been complied with. You state that you believe the coroner is not picking up on that. Given the nature of these inquests, which are often about what caused the state of mind of the person that led to suicide, how could the coroner's office be strengthened in

that? What would be the expertise that would need to be made available to the coroner's office for that to occur and how could it be provided in a cost-effective way?

Ms COLLINS — Like the previous speaker said, if there are nursing experts in the coroner's office, I do not know about them. That does not mean to say that they are not there, but it would seem to me that there needs to be some independence. Each side may very well bring in experts, but they are working for the person who has hired them and not necessarily for the coroner. I would like to see a situation where the coroner calls in experts — for example, the Nurses Board of Victoria is charged with the responsibility of registering people. It may be that there is an expansion of their role in looking at certainly the nursing aspect of care to see whether people have complied with standards of treatment and care and provided advice to the coroner, but I believe it does have to be independent.

It also has to be what should be getting done — for example, I have heard psychiatrists provide advice and have nearly fallen off the chair at the advice that is being provided. One of the difficulties around mental health at the moment is because there is a shortage of staff, including psychiatrists. What happens when you are short of staff is that you cut corners and you see to the patients most in need at the expense of other patients who perhaps are not as acutely at risk. Because this problem has existed for some time now, that cutting of corners has become normal practice. For argument's sake — and I am not going to remember the title — there is a book that the coroner's office uses in making an assessment about minimum standards that a psychiatrist ought to use. I have got a copy of that book and if you look at that then medical staff are not complying with their own standards as well in conducting holistic assessments. It is not just nursing that needs some independent advice. It is not about what is currently common practice but what ought to be practice as standards dictate, if that makes sense.

Mr MAUGHAN — I am very sympathetic to the argument you have put but I just pose the question, is there any evidence to suggest that better nursing care in terms of what you are advocating — the nurses spending more time with the patient, talking to them, seeing what is motivating them — leads to better patient outcomes?

Ms COLLINS — We do not have enough funding to do the research but the anecdotal evidence is that where nurses do spend time with their patients listening to them and providing the empathy and things like that, that patients are very complimentary in relation to those matters. I need to stress, there are lighted beacons in nursing and in medicine, and they are the people who stand out and do the things that ought to be done but they unfortunately do not form the systemic thing.

I am an Australian Council of Health Care Standards surveyor so I get to go across the country surveying hospitals. Part of my role is to interview patients about what their experiences have been. Most are very critical of psychiatrists and nurses. In instances where — for example, down in Tasmania — the nurses are actually doing what nurses ought to do, and I could not find anybody to criticise, and they talked about how that impacts on them. We have had plenty of patients in this state say that the empathy demonstrated and understanding and support when people are going through psychosis, when that is given, it is a major contribution to their recovery.

Certainly I think, again based on consumer feedback, part of the resistance that patients demonstrate in relation to accepting medication and things like that, is their way of fighting the system. Because psychiatry is really the only area where medical and nursing staff can impose treatment and care on to a patient against their will, some fight that as their only way of fighting back about how they were treated. It has certainly again been my experience where the person is treated with respect and dignity and all of those sorts of things, and they are provided with holistic care and treatment, they are much more responsive and they are also much more likely to tell the person how they are feeling if they have got somebody that they can trust.

I am very disappointed that the coroner's office is not picking up on that fundamental principle of nursing, which is that you do your patient no harm, you take care of them and have them feel safe and secure. A very good example of the difficulty is a young woman who was, as a high school student, pack-raped on her way home from school. It is understandable that this young woman has never been the same since. Every now and then, every couple of years, she relived that experience. She was in her 20s; she kept a diary and she wrote in the diary that she decided to go into a public hospital for support. She went in, was examined by the medical registrar, and there were four lines in the medical file. Having never been seen because she had never been in the public mental health system before because she had been treated by a private psychiatrist, having never been seen by the consultant psychiatrist, there were four lines in the medical file, and they decided that this young girl had schizophrenia. How you do that is beyond me, given that psychiatry is not an exact science.

This young woman decided and told the nursing staff that she was not getting support so she was going to go home. They told her that if she attempted to leave, they would make her involuntary. She hanged herself on the ward. Again, there is not a single, solitary sentence in this file to demonstrate that anybody was concerned about how this girl was feeling, how she even might feel. The diagnosis of schizophrenia, I doubt whether it was right but it may very well have been right, but there was nothing there about how this girl felt about having a diagnosis of schizophrenia, what this meant for her and what she understood about it — just nothing. I have been advocating for the parents. We have met with the QC. I recommended that a nursing expert be called to give evidence before the coroner, and the QC's response was, 'The coroner will never accept nursing expertise'. I do not know how coroners have the right to decide something as important as that. It seems to me that you have got to be much more open in relation to recognising that nursing is an independent profession, has its own expertise, and lawyers and doctors are not experts on that, in the same way as nurses are not experts on medicine or law.

Mr MAUGHAN — Maybe the QC was not well informed either?

Ms COLLINS — The QC seemed to know that particular coroner, and said that they were very — I am sorry I cannot think of the other word, but what she was implying was anally retentive.

The CHAIR — I want to ask you a couple of things in relation to the submission from the coroner. The first one is in relation to mandatory inquests for in-care deaths. The coroner indicated he did not think it was always necessary to have an inquest into the death of a person who dies while they are on a community treatment order, and I just wanted to get your comments on that. The coroner also indicated that in relation to the current requirement for mandatory inquests for deaths in care, that it be amended to only require inquests when the cause of the death in this group of people is unknown or not a natural cause of death. Can you comment on those two aspects: the community treatment orders and non-mandatory inquests for death in care?

Ms COLLINS — I would not agree. I certainly think that both should have an inquest. Somebody on a community treatment order is an involuntary patient living in the community, and one of the reasons why is that if we got it right in relation to rigorous assessment, health professionals will argue that often they put people on a community treatment order to assist in developing a relationship with the patient. Feedback, and I have been there when patients have asked me to attend consultations with the psychiatrists, is usually, 'Are you taking your medication?'. They might say to them, 'How are you going?' and they will say, 'The side effects of the medication are shocking', and they will say, 'Okay we will see you next week'.

I dare say you would find the same thing in the community — I know you will — that there are people spending 2 minutes with somebody when in actual fact they should be spending an hour trying to find out how they are feeling, how they are going and all of those sorts of things. People, particularly those with a diagnosis of schizophrenia, do not have much choice in life in the sense of, they either have got horrible voices screaming in their ears telling them dreadful things, which is constant; or they take medication which may very well dull the voices but not necessarily take it away, or it makes them feel so sedated that they deserve a gold medal just for getting out of bed. Many of them will have that moment of insight where they say, 'This is my choice in life: I have these voices or I have this medication — I want out of this.'. One has to respect that. However, I do not know how many of them would make that decision if we had a more humanistic way of caring for people. In our office we get people coming in all the time who are quite unwell. Our philosophy is empathy, plus plus plus, in trying to support them and understand them and show understanding and all that sort of stuff. From my experience, it does work and it works very well.

The CHAIR — I think the question here is the coroner was suggesting that from the case records you should be able to make a decision about whether an inquest is necessary in all cases, that it should not be mandatory under the legislation but there should be some discretion. Obviously there is an investigation but not necessarily an inquest, and that is specifically what I was asking about.

Ms COLLINS — The comment I would make is given the lack of rigour by the coroner I would be loath to agree to that at the moment. If there was more rigour and I thought it was going to be absolutely thorough, then I would agree to that. If there was funding for psychological autopsies and things like that, then I probably would not have a problem with it. However, we do not have that funding and we do not seem to cover it. Even though the research evidence shows that the psychological and social impact on people is a major contributing factor to suicide, we are not looking at those matters.

The CHAIR — Thank you for that. Thank you very much for your submission, it has some quite compelling case studies in it. I think you made your points very clearly in the submission and they are very helpful to us. Thank you.

Witness withdrew.