November 6, 2009

The Secretary
Senate Inquiry into Suicide
Community Affairs Committee
Parliament House
CANBERRA, 2601

**Introduction**

My daughter, Natasha Snow, at age 30, took her life at the Currong flats in Canberra City on 12th September 2003. She was living on her own in Mawson, ACT, and I had stayed with her for two nights before her death. This submission relates to her death and the reasons for it in so far as the family could determine. Natasha had her illness for over 15 years. The family believes that Natasha took her life primarily as a result of her long and frustrating illness, paranoid schizophrenia.

A combination of many events led to her successful attempt at taking her life on 12th September 2003. They included:

- The illness itself;
- An improved effect from her most recent treatment (risperidone), in that 'voices' that she had become used to had ceased;
- Acute anxiety from the normal trauma of life and being separated from years of associations with delusions and voices;
- Imagined physical symptoms resulting from that anxiety;
- New medication, diazepam, which she was unused to, was given to her on the day of her death. This may have prevented any fear of carrying out a method of suicide which research had shown her would work. MIMS pharmaceuticals guide 20th edition states:

  > 'Valium' (diazepam) 'is not recommended in primary therapy in patients with depression or psychosis. In such conditions psychiatric assessment and supervision is necessary if benzodiazepines are indicated. Benzodiazepines may increase depression in some patients, and may cause deterioration in severely disturbed schizophrenic patients with confusion and withdrawal. **Suicidal tendencies may be present or uncovered and protective measures may be required.'**

- Actual physical symptoms, a hernia, which had been delayed for a month, pending tests for a urinary infection – later found to be negative;
- Her being alone at the time of death. Contributory factors were:
  - A lack of communication by professionals to family concerning the possible consequences of her mental health improvement (first three dot points above), apparently due to privacy considerations,
  - Absence from family contact for a few hours,
  - The effectiveness of risperidone medication in reducing delusions and voices which were her constant companions for about 15 years, and the absence of which created a real feeling of loneliness and an inability to cope with living on her own,

- Poor communications between professionals with Canberra Hospital not being aware of her history in assessing her hospital needs (available from her psychiatrist), the case manager not knowing or not being made aware of the danger Natasha would be in that day following the taking of diazepam; nor did he know the reason for non-admission at Canberra. Calvary Hospital, also in Canberra, was unable to admit her.

**Natasha's future if she had not taken her life**

Our concern is that during some years of difficult coping Natasha had episodes of success, even distinctions, in university subjects. There is growing evidence, including medical research and clinical evidence that people with schizophrenia who reach middle age can learn to cope and deal with the illness. Natasha was 30, showing improvement. With the help of her family and better coordination by practitioners she may have become a productive member of society as well as the loved relative and friend she already was.

Many years ago it became clear that the lunatic asylum concept was cruel, outdated, inappropriate and destructive. The institutions were rightly wound down and many people were kept at home or in their communities. However the change left an empty house for many patients. Those who had no family, those who could not or would not reconcile with family or friends or those with paranoia, were examples of the people who were left to deal with, even submit to their voices, their 'black dog' depression, their mania, and their delusions with little help from anyone.

Her psychiatrist stated in evidence presented to the Canberra coroner that if Natasha felt she should go into hospital she should go to hospital. Natasha always responded well to hospitalization. Her prospects for survival would have been better if she was admitted. It is clear that there was pressure on beds and it is clear that hospitals are expensive places to operate.

For that reason we support the concept of a less expensive hostel arrangement with at least one mental health nurse present on weekdays and available on call at other times. The hostels should accommodate a larger community of people than the houses at present provided by some organisations. These houses, accommodating just a few people, while often helpful, are also often very difficult for newcomers because of the narrower range of personalities, the reduced opportunities for companionship and the initial, sometimes lasting discomfort felt by newcomers and residents. Making a fresh start, we would not have to go back to the old asylums.

**Recommendations**

1. Provide community services with better coordination and information exchange between professionals, institutions and with families and/or friends.
2. Prescription of mind-altering substances should be associated with constant supervision of the patients, in accordance with the professional experience and recommendations.

3. Provide targeted and systematically graded services to the mentally ill as we do for the aged, though not modeled on those for the aged. There should be alternatives based on care in the community, accommodation in houses, accommodation in larger supervised hostels with respite care arrangements, and accommodation in psychiatric hospitals with flexibility in moving between all these.
4. Supervised hostels should be available for people like Natasha who are able to live in the community but need occasional respite, on request of the patient and a professional. They should also be available for people who need constant supervision yet do not need to be hospitalized or constrained.

People would benefit from graded and properly provided services giving due regard to needs ranging from forced detention through permanent live-in care, medium term live-in care, temporary live-in care, respite care and consistent, community based care.

Mental health hostels, large enough to accommodate a community of people, rather than just two or three, could have a manager, trained staff and one or two nurse supervisors, the latter working on weekdays with expertise available on-call at other times. Beds could be available for permanent, medium term and temporary respite allowing movement between community, hostel and more intensive care and/or hospital.

Properly done, the cost of a flexible system of care for mental health patients would be reduced by greater efficiency, the avoidance of high police, hospital and other costs associated with suicide, suicide attempts, violence, family breakdown and delayed corrective action.

The cost of supervised hostels, whether operated by government or community organisations, could be assisted by a charge to the patient related to a portion of income including Centrelink benefits, up to a ceiling, for the time spent in the hostel. Private enterprise operators may be more expensive or less helpful to patients because of the legitimate need for profit.

**Conclusion**

Natasha’s illness was the prime cause of her death. There is increasing evidence that people who reach middle age after a long period with mental illness can learn to deal with the illness if given appropriate care, therapy and security. Natasha lacked all three because her illness caused inappropriate reactions to all three, and because there was too little in place to deal with those reactions. It is suggested that better attention be given to the administration of new drugs and that supervised hostels be provided for those patients who are not considered to need hospital and where a house or unit is inadequate.

Thank you for the opportunity to place this before you.

Yours sincerely

Jim Snow
(James H Snow)

NOTES
In October 1993:

> Human Rights Commissioner Brian Burdekin delivered a scathing report on the care of the mentally ill, a 1000 page litany of tragedy, neglect, abuse and ignorance, of squalid housing and jails and living on streets. The then Community Services Minister Brian Howe said an inter-departmental committee would examine the report and the Health Minister Richardson said more funds were inevitable.

About Jim Snow.
I worked for over 30 years as a pharmacist, retiring in 2004.
I was a community social worker for nearly two years.
I am a foundation member of 'Home in Queanbeyan', a facility for accommodation for the mentally ill currently under construction with the assistance of federal, state and private sector funds and donations.
I was the federal member for Eden Monaro in the Australian House of Representatives from 1983 to 1996.