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Senate Community Affairs Committee

The Senate Inquiry into Suicide Prevention

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[redacted]

November 15th, 2009

Thanks to the Committee for this opportunity to contribute to their investigation into suicide prevention. This paper is restricted to my knowledge of mental illness and suicide prevention among the seriously mentally ill (SMI) cohort in Victoria. But what is written possibly represents the treatment of our most severely ill nationwide.

The SMI are those who suffer from schizophrenia, bipolar 1 disorder and severe clinical depression: these persons are most at risk of suicide. Congruent with global statistics, the SMI make up 3% of the population. They number about 115,000 persons in Victoria and 700,000 in Australia.

About 60,000 SMI are treated in the Victorian Mental Health System, (MHS), 10,000 are privately treated and 45,000 seriously ill persons have no specialist mental health care. These range from the more fortunate, who have the best mental health care as is possible from a good general practitioner, to the most unfortunate, persons whose untreated disease worsens as the sufferer sinks into homelessness and suicide. Neither the Victorian Department of Human Services nor any other entity collates the natural or suicide deaths of homeless persons. Council to the Homeless believes that, of Victoria's 25,000 homeless, at least 40% are mentally ill, i.e., a minimum of 10,000 SMI persons.

Suicide rates

Suicide prevention must have, as a firm base, knowledge of accurate yearly suicide rates from all states to calculate the success or failure of types of prevention methods used: there are no such rates available. Rates in Victoria have been understated for many years:

> The data on the rate of deaths of patients with schizophrenia are problematic. The orthodox view is that completed suicide rates range between 10 to 13%,

> and attempts at suicide by persons with schizophrenia are made at 2 to 5 times that rate. Put another way, the risk of suicide for schizophrenia patients is 20 to 50 times higher than for the general population. In addition, it is generally said that patients with schizophrenia represent the highest risk group in psychiatry. If such figures are apposite for Australia, it is apparent that figures made available by the Victorian Office of the Chief Psychiatrist have serious flaws. [1, see Endnotes] Emphasis added.

Victoria is not alone in having questionable suicide statistics. The Australian Bureau of Statistics (ABS) states, at the end of a 10 year national suicide rate table (1995-2005):

> Although death rates for suicide appear to have fallen, these deaths have been under-enumerated in recent years so the actual trend in suicide deaths is not clear. Emphasis added

'Serious flaws', 'under-enumerated': these describe culpability of a large order, a governmental and bureaucratic neglect of duty of care which adds to all stigma faced by the SMI in their fraught lives. To be satisfied with less than accurate death rates in any health service is to be complacent about unnecessary deaths. There is evidence that such complacency exists and it comes from a surprising source, the Victorian Department of Human Services (DHS):

> There is a well-acknowledged need for timely systemic data collection for suicide and attempted suicide…To date, most suicide prevention strategies, including Victoria's, **have not been determined by a solid evidence base and rely largely on assumed efficacy with little or no research.** [2]
>
> Emphasis added

Regarding the fact of false suicide statistics, Dr I Freckelton SC, quoted in [1], offers an even more telling statement:

> There is a need for epidemiological analysis of the incidence of suicide amongst those with psychiatric disorders within Australia so that the

> phenomenon can be better identified and understood. For that to be accomplished, a preliminary challenge is resolution of the disjunction between correlations of completed suicides and mental illness and official government figures. Only when the data are reliable and can be studied more effectively is there likely to be appropriate community pressure for government to take those steps which evidence discloses can be taken to reduce this tragic category of deaths. Those who have already passed away and the families who continue to grieve for them deserve the compilation of such data, the effective integration of clinical knowledge into coroners' decisions and informed governmental and clinical responses so as to address the tragedy of premature deaths of persons with psychiatric disorders. [3] Emphasis added

Suicide data is not reliable. Persons with psychiatric disorders die by suicide prematurely. How many of these premature deaths occurred because of what DHS terms “assumed efficacy”, which is, indeed, nothing more than anecdotal evidence? It is not possible to believe that the most seriously ill patients of other health services receive crisis care based on anecdotal evidence. Only in mental health services does this seem to be seen as adequate clinical care. The dereliction of duty of care, the falsification of suicide statistics; these are two branches of the tree whose root is, and always has been, ‘what does it matter?’.

For example, there was a large ten year project begun, 1992-2002, by the Office of the Chief Psychiatrist and the Coroner's Office. It collated the deaths by suicide of 1837 clients of the Victorian MHS. Some minor conclusions were made public in The Age, December, 2004, but this very important piece of research was left unfinished. There has been a farrago of reasons given over the last five years as to why this will be/won't be finished. I believe it was not and will not be finished because it can be deduced, from figures in the Age article, that MHS suicide rates in Victoria increased 81% between 1992 and 2002. (The MHS client number in that period increased by 44 %.) That ten year project has been locked in a drawer...or shredded. The huge amount of data from a proper study of 1837 MHS suicides could have saved more premature suicides.

For full details, see [4]

The severely mentally ill

Persons with schizophrenia and bipolar 1 disorder have biological brain diseases, cruel and incurable; the damage to brain tissue can be seen by magnetic imagery resonance scan (MRI). The SMI community has a 25 year lower life expectancy than other Australians, about the same as our indigenous community has. Premature natural death usually occurs from cardiovascular disease, diabetes and the problems of morbid obesity and co-morbidity. Antipsychotic medications cause dangerous and disturbing side effects, which for most females include large weight gain. The SMI, all in all, are vulnerable, neglected, stigmatised. The greatest stigma offered to the SMI comes from all Australian governments. They are proven experts at writing and publishing plans to improve mental health.... stack upon stack of illustrated, glossy papered, fully graphed, brightly covered books (costing tens/hundreds of millions?). These represent little future reality for the SMI. Mental Health Minister Neville speaks of the problems caused by **"the unfinished service improvement of the last fifteen years".** Exactly! Emphasis added. [5]

Ominously, the Minister also writes "Services are too focussed on the most severely ill, and give inadequate attention to children and young people." [5]

Children and young persons must be given the help they need: the previous government agreed to fund 30 clinics of Professor Patrick

McGorry's Headspace to help young persons across Australia; but much more should have been done much earlier. The fact that there are needy young persons in no way gives governments a moral licence to lessen care for SMI persons in their 30s, 40s, 50s. These are precious also, the battered and bloodied veterans of that "unfinished service agenda of the last 15 years". As such, they deserve to be provided with all that is necessary for well-being and as much improvement as may be possible for them. They have survived the cessation of psychotherapy and the grave (in every sense of the word) choice of deinstitutionalisation, which killed so many of their comrades in the MHS. (The 10 year rates of suicide, 1992-2002, show a 1997 spike of suicides after mental health rehabilitation hospitals were destroyed by deinstitutionalisation.) This could have essentially been a sound step in the care of the SMI. But nowhere in Australia was deinstitutionalisation done well or sequentially. The first stage, the destruction, was effected quickly (all that land waiting to be sold!). The second stage, of building more acute beds, rehabilitation beds, numerous new community health centres, intensive psychotherapy, adequate housing, excellent clinical care, increased professional staff…<u>all these fall within what the Minister sees as "the unfinished service improvement agenda of the last 15 years".</u>

> "There are now sufficient data addressing suicide as an unwanted outcome of deinstitutionalization to question seriously policies that have been driven more by ideological and financial considerations, than by clinical outcomes. A decade ago the English sociologist, Jones (1993) stated that "nobody seriously argues for the return of the old mental hospital system, but its abolition has left a chasm between intention and performance. [6]

To prevent suicide

Globally, suicide statistics remain, at best, about 10% for persons with schizophrenia. For the present, tragically, this is a given. Suicide rates for schizophrenia may well be 15% or more here in our deinstitutionalised world, where accurate enumeration is not seen to be necessary. Bipolar 1 disorder and clinical depression have lower rates of suicide. Access Economics has stated that mental disorders are connected with 90% of suicides. To provide for the SMI to have as good, productive and long life as possible, without premature suicides, there are three necessities:

1...**medication** This is provided by the MHS to its clients, others have regular scripts from general practitioners. It is hard to imagine how the 10,000 homeless can take charge of medication, keep it safe, get new scripts, remember times and doses (**if** they receive treatment; most do not). "It is not possible to treat a person's mental illness when he or she calls a street corner home." [source unknown]

2...**psychotherapy**...is essential for helping the SMI cope with their intractable diseases and gain insight into understanding their condition, cope with delusions, voices, paranoia...it helps them to become all they can be. In Victoria, psychotherapy was stopped by the government of the mid-90s, for 'economic' reasons. The economy may not have been good, but it is unconscionable to save money by eliminating a clinical necessity. It is the equivalent of stopping blood transfusions for persons with haemophilia. The College of Psychiatrists did not, as far as I know, make any attempt to stop this happening. The allowance of medibank rebates for psychotherapy from psychiatrists and clinical psychologists has been of benefit to some persons but very little to the SMI. Most have a disability pension and, if in the MHS, suffer from a continuing shortage of psychiatrists; if not in the MHS, they cannot afford private counselling.

3…**housing**…adequate, secure, low rent, long term housing.

The Human Rights and Equal Opportunity Commission (HREOC) states:

> …one of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable and secure accommodation. Living with a mental illness - or recovering from it - is difficult even in the best of circumstances. **Without a decent place to live it is virtually impossible**. [7]

The HREOC wrote this 16 years ago. Their deep concern has not been taken up by any Australian government since then. Never have all governments of all political parties been so united in purpose: basically to ignore this dire statement, to hell with the consequences. My emotion is a righteous anger, centred on an urn of ashes and the tens of thousands who remain homeless. No other feeling is possible.

Australian governments manage to ignore the fact that our nation is in breach of The United Nation's Convention on the Rights of Persons with Disabilities which we have signed. The Convention states:

> Discrimination on the basis of "disability" means any distinction, exclusion or restriction on the basis of disability which has the purpose **OR EFFECT** of impairing or nullifying the recognition, enjoyment or exercise , on an equal basis with others, of all human rights and fundamentals…It includes all forms of discrimination, **including denial of reasonable accommodation.**..
>
> To ensure access by persons with disabilities to public housing programs.
>
> Emphasis added.

Australia's name should be removed from the Convention, which is a legally binding document under international law.

Parkville Gardens, a Melbourne development built after the Games Village was dismantled, was to have 200 social housing units. This became 100 social housing units and a 140 bed aged care hospital. [8] When I queried how many housing units were available for mentally and physically disabled persons I received this reply from DHS:

> Port Phillip Housing Association advises that 81 of 82 units have now been allocated to tenants, with the remaining 1 unit being allocated by the Disability Housing Trust for people with a range of disabilities. Emphasis added

Such government/bureaucratic attitudes are common and the reason why so many who care about the fate of the disenfranchised SMI were disappointed by the government's White Paper, made public last year.

The Mental Health Council of Australia (MHCA) published a paper in reply, Home Truths, March 2009. The following statements are from this report.

1…"The recent Australian Bureau of statistics (ABS) survey into Mental health and Wellbeing revealed a further tragedy—that in the ten years since its last survey, the percentage of people with mental and substance use disorders receiving proper care actually appears to have fallen in Australia, from 38 per cent to 35 per cent. Put another way, 65 per cent of people requiring mental health care do not receive treatment. These are stark and grim parameters within which we must work to address the obscenity of homelessness". Emphasis added.

2…"The link between mental illness and homelessness is intimate and clear. Simply put, the Federal Government's ability to meet its ambitious goals in addressing homelessness at all levels depends largely on governments changing their approach to managing mental illness."

3…"the MHCA sees the White Paper's policy of "no exits into homelessness" from hospitals, mental health services, alcohol and drug services and prisons as a major initiative which can make a real difference. As things stand today, discharge from these institutions into homelessness or unstable housing is not uncommon for many people with a mental illness. If ending this practice is the only good achieved under the White paper it will be deemed a massive success for people with a mental illness." All statements from p.5

4…"Properly resourced and monitored discharge planning must be implemented across Australia, with zero tolerance for discharge from hospitals to homelessness and unstable housing. **This goal must be independently monitored and publicly reported.** Emphasis added, p.38

5…the failure to increase community-based treatment and support services has contributed to and exacerbated difficulties for people with a mental illness in accessing the stable and appropriate housing that is an essential prerequisite for effective treatment and support." p.23

6…"National research to build a greater understanding of the connection between mental illness unstable housing and homelessness must be a priority, with appropriate funding and support for this research." p.4

"No exits into homelessness" <u>must</u> become law. The most dangerous time for an SMI suicide is immediately after overnight leave or discharge from a hospital or psychiatric centre. I believe the states must now be doing all in their power to prevent "no exit into homelessness" being made law, for obvious reasons. The Committee must do everything in its power to see that this is not allowed to happen. <u>It is an essential suicide prevention policy.</u>

The Victorian government commissioned the Boston Consulting Group to report on the seriously mentally ill. A report was published in June 2006, Improving Mental Health Outcomes in Victoria. The following statements are from this report.

1…"Access to appropriate non-clinical support services—e.g., housing employment and treatment for drug and alcohol abuse—is critical in recovery from and the management of mental illness…The nature of mental illness, (particularly severe mental illness) makes it even more difficult for those in real need to get the services they require." p. 23

2…"There is a lack of connectedness between parts of the mental health system which means that "whole of person support" provided to people with mental illness is often inadequate. p.69

3…"Improving the mental health system will also improve social outcomes. These gains may be greater than those to be had in many other areas of social policy, given the extreme distress that gaps in the treatment and support of people with mental illness can cause."

Emphasis added p.41

There is an emphasis on housing and homelessness in this submission. It could have been written in no other way since I am convinced that without adequate, secure, low rent, long term housing many of our most neglected and vulnerable people cannot survive…but how can one convince governments?

Our seriously mentally ill are indeed the loneliest people in our society. Any talent or creativity which may have illuminated their earlier lives is diminished and disappears as their disease worsens. About 60% have rejected or been rejected by their families. Most lose old friends along their disease path. About 67% of females have been sexually abused (and many men also) and, for theses females, males form a large background to their paranoia and delusions.

Our homes are havens to us. How much more a haven would homes be to the SMI, our very large group of perhaps 500,000 asylum seekers. For them, secure, adequate, low rent long term housing, with home and community mental health care would be a safe refuge. But also much more; perhaps, for the first time, a place for friends and more intimate relationships, so sadly lacking in these persons' lives.

The Australian governments must fund care for all our mentally ill citizens, not just half of them. We are a rich country: to do less is to continue to act as a third world nation, since we allow our indigenous persons and a vast number of our seriously mentally ill to have 3rd world living standards. The SMI must have medication, psychotherapy at least twice weekly and secure, adequate, low cost, long term housing. The MHCA said some years ago "Fix mental health and you fix health" **Mental health is funded far below the disability burden which the seriously mentally ill bear**. Do Australians want to be subsidised by our most vulnerable persons. Let us be the first nation to fix mental health. More than any other action, it would bring world kudos to the leaders of Australia.

Respectfully submitted,

"...no war in history has produced so many victims, wounded so many people. No earthquake has exacted so high a toll; no other condition that we know has deprived so many people of the promise of life."
Silvano Arieti Schizophrenia Association (now Sane Australia)

Our personal journey…

We discovered my daughter Anne had a schizoid type disorder when she was 30, in 1992. Looking back, there were earlier signs which were not picked up by me. She refused to see a doctor because she did not believe she was ill. No doctor would see her because she was an adult and refused medical attention. This, despite the fact that I described her paranoia and delusions to them. Because she was not harming herself or anyone else we could get no help…I'm sure this is unchanged and others now go through the same nightmare.

This lasted for two years. Anne became worse, smoking and drinking because "it helps the pain in my head". She stayed at her brother's apartment one night, got into a bath of water and cut her arm with a Stanley knife. She was saved by a hospital's excellent microsurgery and was then admitted into the mental health system, diagnosed as severe paranoid schizophrenia. She spent 9 days in an acute hospital, I was in a bed beside her. Then a rehabilitation hospital for 5 months. I visited her every day. Anne would never come to my house because she believed that the men trying to torture and kill her had found it and would kill her there. When discharged she went to live in an apartment.

The next years…difficult adjustment to medication; constant delusions of being stalked; terrors of being raped (she had been raped by several men when in her mid-twenties); put on 22 valium a day by her psychiatrist, thus acquiring an addiction which she fought for the rest of her life; worsening of her state and another rehabilitation hospital for 4 months…there she was placed on clozapine and, for the first time, was without the voices which bedevilled her life; then a relatively calm two years, where we found good supervised accommodation and symptoms seemed to improve.

Anne's condition slowly deteriorated again as voices and delusions returned; she was missing for two days but found in her bedroom after another suicide attempt, overdosing on drugs. Hospitalisation again; her life was saved and there was no further brain damage apart from what the disease was causing. When I asked 'why not let me know the pain?" Anne said "if you helped me they'd get you for murder". After another year she and a friend were given a Richmond Fellowship apartment which made them both very happy: these 6 units for the mentally ill back onto a railway line.

Anne was calmer and enjoying life a little more. She took up her art work and photography again (Tim Winton, the internationally famous photographer, saw a posthumous exhibition of her works, which I arranged for mental health week. He said "She had an awesome eye".) But her creativity and talent had so much been diminished by schizophrenia and her pain about this was hard for us both to bear.

Anne deteriorated further, stopped taking her medication (as I learned later) and went into a rebound psychosis, losing her thought processes and speech. She was in hospital for 37 days, slowly titrated up on clozapine , (in her 4 years on that drug Anne went from her normal 48 kilos to 105 kilos). Anne recovered her speech and thought processes but was severely paranoid and deluded. We would walk in the park, go out to eat…her condition made me frantic, her paranoia was worse than ever. They insisted we go on overnight leave at her place. Neither of us slept well as she believed the killers had found her there. All this I told to the medical staff. Anne was told by them that she must go on leave overnight without me if she wanted to be discharged. I had a letter placed in her file detailing her condition and my fears for her safety. She was sent out and 30 hours later she died, purposefully and finally, by placing her head on a railway line at about 11p.m. and waiting.

One of my sons comes at 8a.m and tells me. I don't believe him, but somehow I break in half, I am clutching David, screaming it isn't true, I am screaming in my head "I want to kill that doctor who made her go on leave, I want to stab him in the heart, I want to kill him"

We receive her body six days later. I hold her shrouded broken body for a long time, lying half on the gurney myself, at one with her physically for the last time: the most painful and precious memory of my life. I would have helped her do it, non-violently and with me, but I never had the chance to do so. I knew her great pain and suffering . Her resources were gone…death more desirable than facing her diminished, painful life any longer. She did what she needed to do.

And so…the days go by in leaden pain, day 10 her funeral, I have them read from Oodjeroo Noonuccal:

Life is ours in vain
lacking love, which never
counts the loss or gain.
But remember, ever
love is linked with pain.

Grief is not in vain,
it's for our completeness.
If the fates ordain
love to bring life's sweetness
welcome too its pain.

And the days go by… the only purposeful thing I do is count them, and feel the physical pain in my heart…it is not as self-threatening as the other pain, the one that screams “mothers should protect their children”.

I wake on day 150 and feel strange; the pain in my heart has gone. I weep, I don’t want to lose it…but I have. My heart doesn’t pain physically any more; Anne is there.

I write a long letter to the coroner for, after receiving her medical history, I must live with the fact that she was sent out without a risk assessment or even a signed leave form, that she was seen by her psychiatrist five times in those 37 days, that his last note assessing her condition is written on February 28th, that his next entry is on March 17th, the day after her death. He is sorry she died.

We wait 18 months for Anne’s inquest. It lasts for five terrible days over seven months. The hospital has secured a barrister from our most expensive legal firm and I am cross-examined for five hours in all. Her parting question is “If you knew how ill she was, why didn’t you save her?”. Our barrister fights hard for Anne’s cause.

We wait six months for the coroner’s finding. It is nine pages long, three of those a medical history of my daughter written by her psychiatrist from the hospital. There are three “motherhood” recommendations, all of them already in the hospital’s Practice and Procedure manuals. At last I crack, slam the paper down and leave the coroner’s office, go outside and scream and scream and try to pull a sapling out by its roots; I guess I want to kill anything. My daughter and friends find me and I go home to a renewed grieving. Is anybody there? Does anybody care?

I sink into a depressive state. My clinical psychologist who helps me see that I must begin medication. I do, and I respond well. With that, and his counselling, I very slowly improve and move back to life again.
I am now resilient and powerfully motivated to try to help those who struggle to stay alive with their severe mental illnesses. Anne has left them as my legacy. It is nearly eight years since we lost Anne…but she is with me throughout every day…her spirit and strength motivate this submission and all that I do.

Thanks to those who read this. Anne's story is one of tens of thousands, and they must be heard. Some of those who hear will fight harder to save the seriously mentally ill struggling to survive…so many of them without the help which surrounded Anne…but could not save her.

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ENDNOTES…Suicide prevention

1…*Psychiatry, Psychology and Law*, Nov. 2005, p.265,
The Myers Oration, Dr Ian Freckleton

2…*Next steps Victoria's suicide prevention,* DHS 2006, p19, p9

3…*Law Reform Committee, Coroner's Act, 1985, Final Report*, p336
Dr Ian Freckleton

4…attachment, What is known of clinical research in the MHS

5…*Because Mental Health Matters*, DHS, p13
Mental health Minister Neville

6…*Crisis*, volume 24, p39-40, Deinstitutionalization and Suicide
Robert D Goldney

7…*Human Rights and Equal Opportunity Report*, 1993
(Burdekin report)

8…attachment, Commonwealth games village and social housing

What is known of clinical research in the Mental Health System

It would appear that no major research on the **clinical care and suicide prevention** of mental health clients has taken place in the department for two decades. This period covers **the two greatest clinical changes in the care of clients ever**; firstly, the cessation of regular client counselling, for economic reasons. Research in many countries shows that psychotherapy is **crucial** for the optimum survival rate of the seriously mentally ill (SMI); secondly, the action of deinstitutionalisation, which unhoused so many who needed asylum for shorter or longer periods. **And, tragically, no one cared enough to find out how clients were affected by two such serious matters.**

Unfinished suicide research

Dr Vine, the Director of Mental Health, gave an interview about two projects, from 1989-2002. (The Age, "Suicide a risk after hospital", Dec. 12th, 2004, Liz Porter)

1...1989-1994...an audit by the department, identifying 629 suicides by clients of the MHS. This is an average of 105 suicides a year. In December, 2000, an article was published in the *Psychiatric Service Journal* concerning this audit.

2...1992-2002...a joint project of the office of the Chief Psychiatrist and the office of the State Coroner for 10.5 years. This covered 1837 suicides of MHS clients.

Dr Vine's figures allow a comparison between the two suicide rates. From 1989-2002 the client suicide rate rose by 81%. During this period the number of MHS clients increased by 45%.

No further information has been made public regarding the second study which, it is reasonable to assume, was originally a major research project. It has to have been: a survey of the whole of MHS over ten years, two Government offices using two senior researchers for 10.5 years to collate and examine information about 1837 client deaths while, at the same time, there took place two dramatic changes in clinical care. It is clear from what follows that the research became of little consequence...it has been designated disposable and "preliminary". Such a disposition, unethical, professionally a neglect of duty of care of present clients and the ultimate insult to those who died during those years, is a continuation of that stigma which so affected our children when they were part of the system, as all carers know.

What has been told about this matter

1...I did not give an interview to the journalist. She must have the figures from someone else in the department. Dr Vine

2..."That calculation [an 81% suicide increase] is incorrect". Dr Vine

3...I can do nothing to help get more information. Chief Psychiatrist

4..."The research conclusions can't be made known until we publish professionally." Dr Wallace

5..."...as the person who carried out the research had moved to another position, **the research has not been completed**." Emphasis added. Dr Vine

6..."The report's conclusions should be viewed as "**preliminary**". Dr Vine Emphasis added.

7... "Dr Vine expressed the hope that the department would be able to carry out similar work in collaboration with the State Coroner's Office **in the future.**" Emphasis added.

8..."I have been informed the work done by the Department of Human Services as discussed with Ms. Porter **was preliminary only and was never meant to be a major research work**. The purpose was to provide useful information on death by suicide to assist in the development of a proposal for discharge support and engagement with general practitioners." Health Commissioner
Emphasis added.

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9...Dr Vine said that she will try to get Dr Wallace to finish the report. *9

10..."Dr Ruth Vine...said the aim of the project, **which is not yet complete**, was to identify risk times and risk factors for suicide." Emphasis added.

1-4 my phone conversations

5-7, 10, information in the Final Report of the Law Reform Committee

9, reported to me, email, by the senior researcher from the coroner's office

What can be deduced from these statements

The explanations offered regarding this research are inconsistent, unprofessional, insulting and intolerable: in 2004, 12 years after its start, we are told the work is not yet complete; in 2005 we are told it is not finished because "the researcher moved to another position" and that it was only ever meant to be "preliminary" and, anyway, perhaps similar work can be done "in the future"; in 2006 we are told the work was "preliminary only" and never intended to be "a major research work"; in 2007 we are told that it is hoped to have Dr Wallace return so that the project can be finished.

What such dereliction of duty of care means

A research project covering 10.5 years and nearly 2000 suicides of clients of the MHS is classified as "preliminary" and may be repeated "in the future". What **could** constitute a major research project? The answer has to be, a project which possibly begins in two years in 2010, <u>assuming that to be possible</u>, again lasts for ten years, collates the suicides of perhaps 4000 clients and ends in 2020 (this suicide number is probably low... remember, by then there has been no applied clinical research for 30 or 40 years) and presents results and

conclusions in 2025. If governments and bureaucracy work faster then than now, perhaps the lot of clients could be improved by 2030.
Does this sound like Farce? It is not that. It is Tragedy. Writ large.

Nobody is more aware of this than we survivors of our dead sons and daughters. We watch while the Mental Health section of Victoria's Department of Human Services, regarding ten years of suicide numbers and the information they could provide, appears complacent about seeing such invaluable data as disposable.

Disposable: despite the rising suicide rate, the mentally ill who now constitute, in some areas, 65-70% of the homeless, 40-45% of male prisoners and more than 50% of female prisoners. And our dead; disposed of already. Unworthy even of that research by which their deaths could be the cause of saving others.

It is now June, 2009, and there is still no information as to whether Dr Vine's statement, reported to me in January, 2007, that she will **try** to get the research completed, has any relationship with reality. Indeed, so little regard is given to the death/suicide rates of MHS clients that at present we have no statistics from the Chief Psychiatrist later than December, 2006

Research and deinstitutionalization.

Considering what is known about the ten year project, it is reasonable to assume that it **was** intended to be a major research work. **If it wasn't, it should have been!** Deinstitutionalisation has been a time of research in almost all European nations, many Asian nations and the Americas. **Why was it not here? Did no person want to know if suicide rates changed and how clients were affected according to age, gender and diagnosis?**

Commonwealth Games Village (CGV)...social housing, 2000...2009

A chronological history of the CGV/Parkville offers awareness of past intentions and priorities, from 1999-2009, of Treasurers, the Department of Human Services and Government leaders regarding the matter of our disabled persons and their urgent need for housing. In the end…no priority

1...K. Downie letter to C. Storm, April 18th, 2008

In 2002 it was determined that after the conclusion of the Games 200 units were to be made available for social housing. Of these, 100 were for aged care and 100 social housing. This would provide a lasting legacy in that the Village would provide affordable housing for low income Victorians.

2...October 23rd, 2002, Media release, Office of Premier :

Mr Bracks said he was proud the government had achieved an additional 200 housing units...after the Games, social housing for 200 households will be integrated across the site...and reflects the Government's strong committment to social and environmental policies.

3...The Age, November 11th, 2002, William Birnbauer, Royce Millar :

The State Government has been accused of excessive secrecy and making misleading statements about its plans for the 2006 Commonwealth Games...Last month the Premier said one in five of the new homes...will become public housing after the Games...Justin Madden said the development included 1000 permanent dwellings, 200 of which will be retained as public housing...Australand and the Citta property Group said the 200 social housing figure included a 100 bed aged-care hostel...The remaining 100 houses would be a mix of rented public housing and low-cost social housing.

4...February 25th, 2003, Media release, Minister Madden :

> The Games Village Development will create an important legacy for Victoria...social housing for 200 households.

The word "household" persists. In no way can an aged-care bed be re-defined as a household or a dwelling.

5...May 27th, 2003, The Age, Royce Millar :

> Former Labor deputy prime minister Brian Howe...called on the State Government to be firmer with the consortium, which, he said, was set to make big profits from developing the state-owned former Royal Park Psychiatric Hospital.

6...August 5th, 2003, Media release, Minister Madden :

> The Government has also improved on its plans... to provide 200 social housing dwellings.

7...August 8th, 2003, letter to Age, Minister Madden :

> The facts about the Games village. The Commomwealth Games Village will not be built on "21 hectares of Royal Park", as claimed by Kenneth Davidson (Opinion, 7/8)...The report also confirms that the Government will deliver a **minimum** of 200 units of social housing. Davidson contimues to claim a figure of only 100...Age readers deserve analysis based on fact rather than Davidson's ignorant assertions.

8...October 25th, 2004, Media release, Minister Madden :

> Four apartment blocks for social housing after the Games are complete.

9...October 8th, 2006, Media release, Minister Madden :

> When the development is complete it will include 14 social housing townhouses, a 100 bed aged care hostel and 720 apartments—86 of which will be allocated to social housing.

Mr Madden's statement is the first one I have found which, belatedly, offers the truth. Except, of course, for Mr Davidson's "ignorant assertion" 3 years earlier. (Points 1—9, all emphasis added)

10..October 30th, 2006, Media release, Minister Broad :

> Minister Broad said the first tenant [moved] into the 100 unit social housing development at the CGV on the weekend.

In early 2007 I was able to find out that 4 social housing units at Parkville were managed by Melbourne Affordable Housing and had tenants. In late 2007 I spoke to a DHS oficer who said no further units could be allocated because the Department of Infrastructure had to restore kitchens after the games. Why? The developer was contracted to do that. And so, through the winter of 2006 and the rather more severe one of 2007 these units were empty while thousands were homeless in Melbourne. 81 social housing units were allocated in <u>2008</u>. One unit has been or will be given to persons with a range of disabilities. This accounts for the 86 social housing units. I am unable to find out when the 14 social housing townhouses will be built. The social housing regarding Parkville Gardens and the mentally and physically disabled has a distinct aura of "world's worst practice".