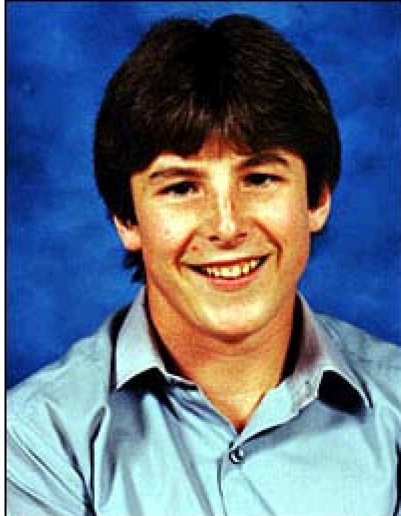
Critical condition

March 17, 2004



Jason Bond
Picture:*Supplied*

Jason Bond suffered from a depressive illness. He was 20 years old when he killed himself after being discharged from a Melbourne hospital. Here, Graeme Bond recalls the events leading up to his son's death, a death which he blames partly on the poor state of mental health care in Victoria.

Until the night of March 29, 1993, I had no knowledge or experience of mental illness and not the slightest inkling that my 20-year-old son, Jason, was suffering from a depressive illness. There had been some behaviour on occasions that had caused concern, but it was easily dismissed as within the boundaries of sometimes difficult, teenage behaviour.

I recall vividly the late-night dash I made to the unit in which Jason had been living with his girlfriend before their break-up.

Earlier, I had spent the evening with one of his brothers searching unsuccessfully for him after a friend had phoned and expressed great concern about his behaviour over the preceding few days. My frantic dash was triggered by a call from my ex-wife who had just spoken to Jason on the phone and was gravely alarmed by the content of the call and his demeanour.

I arrived just in time to see Jason collapse and begin convulsing as a result of a massive overdose of prescribed medication. I struggled desperately to keep Jason alive with CPR until the MICA paramedics arrived. It was a close call, but Jason survived that night and, two days later, he was transferred to the psychiatry department of a major public hospital.

The next eight days were enormously disorienting and exhausting. Within 24 hours of his arrival at the hospital, Jason was discharged without either of his parents being advised that this was going to happen, and a visitor pressured into taking responsibility for him. The same visitor had reported to a psychiatric registrar that Jason had told him that he was going to "con the shrink, get out and do it again".

> I was so numb with grief and shock I had to be driven to the scene. I arrived just as the undertaker was removing my son's body. He had again taken an overdose of prescribed medication.

Despite this, the discharge went ahead. Within a few hours of leaving the hospital Jason had become distressed after visiting his ex-girlfriend and had attempted to ram an oncoming vehicle on a major road. Fortunately, his visitor had stayed with him and prevented a tragedy. He contacted me immediately and together we were able, after several hours, to persuade Jason to accompany us

back to the hospital.

These events were described in detail to hospital staff when Jason was re-admitted and I felt sure they were sufficiently serious to ensure Jason remained in hospital until his crisis was resolved.

Picture:Gabriele Charotte

This was not the case. A few days later, Jason simply walked out of the hospital one evening and went and had a few drinks. He was reported missing and police were notified. Jason was actually making his way back to the hospital when he was bashed to the point of being knocked unconscious and robbed by unknown assailants.

When police arrived, he was agitated and they took him back to the hospital. He was settled when he returned to the psychiatry department, but became agitated again when staff would not take his account of being assaulted seriously.

Staff responded by grappling with him and attempting to inject him with the tranquiliser haloperidol. Jason broke free and staff simply watched while he left the ward at about 3.15am in an agitated state. Their response was to go to a computer terminal and discharge him.

Shortly after this, I received a reverse charges call from a public phone box near the hospital. Jason was sobbing: he was very distressed. Accompanied by his brother, we raced to the hospital and found him.

He was reluctant to return to the hospital after his treatment there and it took several hours, with the assistance of police who had earlier apprehended him, before he could be persuaded to return to the hospital.

The hospital re-admission procedure took several hours and, in an assessment carried out by a nurse and a psychiatric registrar, Jason stated that he "still wished to die" and that he "felt safe in the hospital, but did not trust himself outside not to act on his impulses".

This was recorded in his medical history although later, at Jason's inquest, denied by the psychiatric registrar. Two days later, the same psychiatric registrar allowed Jason to be discharged at his request. Next of kin, who would be expected to look after him, were not contacted at the time or subsequently. No advice as to his diagnosis, how to care for him, danger signs to look for, or any such information was ever provided.

Had it not been for the fact that his 16-year-old brother, a female school friend and his 20-year-old female cousin, were visiting Jason at the time, he would have left unaccompanied.

For the next 24 hours, all concerned felt an enormous tension in Jason's presence. We were dismayed that he was clearly not well, but had been discharged. How could we have him re-admitted to hospital without some quite specific grounds for concern? We felt powerless and tried as best we could to not upset him.

Had we been better informed, we might have recognised some of the subtle indications of impending suicide, such as Jason giving away his prized possessions. Jason left his mother's home in the evening saying he was going to visit a friend. Within minutes, his youngest brother, just 14 at the time, discovered his suicide note. Police were contacted immediately and they began an intensive search, which included the use of a police helicopter.

Jason's mother phoned me and I got her to read the note to me very carefully in case it contained any clue as to where he might have gone. The clue was there but we didn't understand it at the time and he went to a place just outside the search area.

I phoned Jason's friend and asked to be contacted if Jason arrived and for him to restrain Jason if necessary.

Jason had also discovered where his mother had hidden his medication and he had taken it. But

how much was there? Was it a lethal dose? My mind raced as I tried to gather the information and do the calculations.

Inevitably, the dreaded call came. A young man, believed to be Jason, had been attended by ambulance and police and was dead.

I was so numb with grief and shock I had to be driven to the scene. I arrived just as the undertaker was removing my son's body. He had again taken an overdose of prescribed medication. With what I had witnessed just 11 days earlier, I could picture his death.

To this day, that scene returns to haunt me. In a recent letter to the Victorian Government, Dr Peter Archer, director of emergency services at the Maroondah Hospital, re-ignited debate about the parlous state of mental health services in Victoria when he described how 13 patients admitted to that hospital had committed suicide in 13 months.

He pointed to the inability of the facility to provide appropriate care for such patients due to a lack of psychiatric beds. But, while the specifics he pointed to were new, none of the underlying issues were. The same problems that existed when my son killed himself exist today.

In a letter to *The Age* on February 21, Patrick McGorry, professor of psychiatry at the University of Melbourne, said while mental illness constitutes 20 per cent of the illness burden, it attracts only 7 per cent of the health budget. He also noted that suicide now kills the same number of people as road accidents.

In October 2002, the Victorian auditor-general released the report *Mental Health Services for People in Crisis*. 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.

In our mental health system, deficiencies are the norm. This is, no doubt, caused by the under-funding disclosed by Professor McGorry. By my reckoning, mental health receives barely one third of the funding it should, based on the relative illness burden. This situation will not be resolved by opening a handful of new beds, as the Victorian Health Minister Bronwyn Pike seems to think.

Also, in the case of these acute psychiatric patients, talk of community care is about as appropriate as suggesting your local GP undertake major cardiac surgery in his rooms.

In 1993, the year my son Jason killed himself, he had been repeatedly discharged from a psychiatric department of a major public hospital. It was also the year the *Burdekin Report (Human Rights & Mental Illness*) was released. Its two volumes and 1008 pages are an indictment of the systematic neglect of mental health services in all Australian states.

The response to the litany of horrors documented so comprehensively in the *Burdekin Report* was, predictably, denied by health departments everywhere.

The election of the Bracks Government brought a feeling of hope that, at last, the tide would turn and services would be restored to a reasonable level. But the tide has shown little sign of turning. There has been no significant improvement in the public mental health system.

Indeed, some of the worst of the Kennett "initiatives", which were rightly criticised by the then Opposition spokesman on health, John Thwaites, remain in place.

One of the more bizarre amendments to the Mental Health Act implemented in 1995 was the removal of the whole of Section 7, which dealt with voluntary patients. Indeed, as far as the Mental Health Act is concerned, there is now no such thing as a voluntary patient. They have ceased to exist.

Along with the removal of voluntary patients went the right to appeal to the chief psychiatrist against being refused admittance to a public mental health facility.

Interestingly, in relation to his experiences at Maroondah, Dr Archer said in his letter: "It is only the fact that these patients have limited ability to access legal and complaints mechanisms that we are able to get away with the sub-humane care that they currently receive."

All admissions to the public mental health system are now as a result of assessment by a crisis and treatment (CAT) team attending a patient. A CAT team where I live is one person at the end of a

phone outside of the hours of 9am and 7pm.

Outside these hours, a patient experiencing a crisis will be taken to the accident and emergency department of a public hospital by either relatives, ambulance or police where a CAT team will assess them the following morning, if the patient stays.

The presence of a psychiatric patient in a busy A&E department geared to dealing with physical illnesses and injuries is inappropriate: there are no trained psychiatric staff to care for them and they can become a source of disruption and potential danger to other patients. In some cases, they end up strapped to a trolley and attended by a security guard.

When I last checked, the mental health region I live in had 25 acute beds for a population of 450,000.

Confronted with similar circumstances, the New South Wales Government held a parliamentary inquiry into the deaths of psychiatric patients in care or soon after discharge.

The ensuing report, *Tracking Tragedy: a systemic look at suicides and homicides amongst mental health inpatients*, was released in December 2003.

Such an inquiry, broadened to include patients denied admission and the adequacy of psychiatric inpatient services, is long overdue in Victoria. The needless deaths of many patients denied appropriate treatment is nothing less than euthanasia by neglect.

Graeme Bond can be contacted at: vigilance@optusnet.com.au

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