Dr Laurence (Laurie) West Suicide Prevention Submission

Part 1

Scotland achieved a 20% reduction in suicide between 2013 and 2017 when in the same period the Australian suicide rate increased by 20%.

This reduction in suicide rate was achieved by:

- refreshing mental health and suicide prevention training especially in the provision of skills to actively intervene when someone is experiencing thoughts of suicide.
- developing coordinated approaches to public awareness campaigns with the idea of transforming societies response and attitude towards suicide.
- improving the use of data on suicides that is available and reviewing all the deaths by suicide to see what could be learnt to prevent further deaths
- focusing on particular areas where suicide was problematic such as in veterans, rural communities and in men.
- aiming to get help and support available to anyone contemplating suicide and to those who have lost someone through suicide.

A national suicide prevention leadership group was then set up and made accountable to the Health Minister.

Most suicides are preventable. Australia's suicide rate is now at 12.6 deaths per hundred thousand people which is the highest recorded rate in the past 10 years.

I wish to make the following recommendation: that we learn from the Scottish experience and implement similar policies tailored for the Australian environment.

The above data can be located in the following links:

- *https://www.theyworkforyou.com/sp/?id=2018-09-12.15.0*
- *https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3*
- *https://www.theguardian.com/australia-news/2018/sep/26/australias-rising-suicide-rate-sparks-calls-for-national-target-to-reduce-deaths*

Part 2

For a person with mental illness to receive treatment an essential step is that they receive understanding and kindness from treatment practitioners. It is my experience that healing cannot occur without this fundamental ingredient being present irrespective of the modality, length or frequency of treatment.

For a person without private health insurance who has attempted suicide, or is seriously contemplating suicide, the Emergency Department of a public hospital is where they usually have their initial assessment. The quality of the care a person gets at this point is paramount. Too often the patient is treated in a less than humane way without kindness and sensitivity. This means the person is reticent to return for crisis management to an Emergency Department.

The public hospital emergency department sometimes have areas set aside for mental health patients for observation. These areas do not distinguish between patients in an acute state of agitation because they are on recreational drugs and/or are suffering from an agitated psychosis, or from those who are in a state of despair and have attempted suicide or who are suicidal. The treatment area is frightening for those who are in despair and lacks containment for those who are agitated and psychotic.

Follow-up treatment and monitoring for someone suffering from depression and suicidal ideation who is treated in an Emergency Department is critical. Repeatedly I have heard stories of people being turned away from Emergency Departments and later committing suicide or being discharged from Emergency Departments and later committing suicide.

To illustrate this issue, I will use the case of a de-identified person who consulted me for regular treatment. This person was a university student, was on Centrelink benefits, in their mid-20s, was socially isolated and suffered with a chronic mental illness. This person had been repeatedly hospitalised in the public system in the past and eventually committed suicide:

> *From my clinical notes: "text received on a Friday x x 2015 7:24 PM: Dr West I've just overdosed on my mood stabiliser… I feel extremely terrible."*
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> *I rang the person back immediately. From my clinical notes: "…I asked if there was anybody else in the house with them and they said there wasn't. I said I would have to call an ambulance. They said they didn't want me to, they were expensive. I said this wasn't something that I was prepared to negotiate …"*
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> *From my notes: "the 000-operator offered me a 90-minute, 60-minute or 30-minute response time... I told the operator I wouldn't like to see them wait more than 30 minutes as I was unsure of what they would do. The 000-operator said they wouldn't ring the patient in case they cancelled the request for the ambulance and would send an ambulance within 30 minutes. I then rang the patient back and said I had called the ambulance".*
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> *This is an excerpt from my clinical notes in the patient's next consultation with me after the patient's visit to the Emergency Department: "I explained I had not heard what happened in the hospital other than discovering that they had been discharged from hospital the morning after they had been delivered there by ambulance. The patient explained that the emergency treatment staff suddenly announced that the patient had to go home, and they (literally) put the patient out on the street. The staff would not even let the patient wait inside…there was a taxi there, so the patient caught this to take them home. The patient slept when they got home until 4 PM. I asked what had happened while they were in hospital. The patient explained that the overdose of x (mood stabiliser) had really began to hit them when someone came from the crisis assessment and treatment team (CATT team) to speak to the patient at 3 AM and then 5 AM. The patient did not remember the conversations only that the patient did their best to try to wake up and talk. There has been no follow-up from the CATT team."*

This patient later told me they were adamant they would never return to an Emergency Department for help.

This patient's crisis clinical ongoing care occurred in the public health system. This person continued to consult me also. Some months later here is a conversation I had with the patient's treatment doctor from the public health clinic they were attending.

From my clinical notes: "the doctor said in their opinion the patient's suicidal risk had decreased markedly and that the CATT team were no longer needed. I suggested it would be good if the patient could be teamed up with a psychiatrist (a private or public psychiatrist for ongoing management). The doctor explained their service is an acute management team and they could not organise this so I asked them to recommend some psychiatrists in their region as the area I worked in was a long way from where the patient lived (and I was unfamiliar with services in that area)..."

The treating public health clinic doctor then sent me the name of a private psychiatrist the patient could see in their local area but tragically the patient committed suicide several weeks later before further specialist clinical care could be organised.

This patient, when they were not acutely unwell, was highly motivated to seek treatment privately with me and travelled long way by public transport. The patient needed more ongoing support from the public system in an active way, but the public system had limited resources.

I wish to make the following recommendations:

- I recommend that in Emergency Departments that psychotic patients (drug induced or otherwise) are kept separate from patients who are severely depressed or suicidal.

- I recommend that there be a better system of follow-up and monitoring and referral for people who are discharged from an Emergency Department or an acute management area in the public health service.

- I recommend that more resources be given to Emergency Departments to handle patients with mental illness so that the staff handling these patients do not feel so overwhelmed and unskilled.

- I recommend that short-term in-patient mental health emergency wards be attached to Emergency Department and that these be adequately funded. An Emergency Department is only an appropriate place for a person with mental illness as a place of rapid assessment of their mental state. If doctors and nurses and mental health worker's in an Emergency Department were aware they could place a patient quickly in an intermediate and adequately funded holding area, there would be better outcomes for patients with mental illness.